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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone (515)281-3355 or (515)242-6873

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Replace Analysis
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Replace Chapter 65
Replace Reserved Chapters 115 and 116 with Chapters 115 and 116

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Ethics and Campaign Disclosure Board, Iowa[351]

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[Created by 1986 Iowa Acts, chapter 1245]
[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]
[Prior to 9/7/11, see Economic Development, Iowa Department of[261];
renamed Economic Development Authority by 2011 Iowa Acts, House File 590]

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261—47.1(15E) Purpose. The purpose of endow Iowa tax credits is to encourage individuals, businesses, and organizations to invest in community foundations and to enhance the quality of life for citizens of this state through increased philanthropic activity.
[**ARC 8474B**, IAB 1/13/10, effective 2/17/10; **ARC 0008C**, IAB 2/8/12, effective 3/14/12]

261—47.2(15E) Definitions.

"Act" means Iowa Code sections 15E.301 to 15E.306.

"Authority" means the economic development authority.

"Community affiliate organization" means a group of five or more community leaders or advocates organized for the purpose of increasing philanthropic activity in an identified community or geographic area in the state with the intention of establishing a community affiliate endowment fund.

"Endow Iowa qualified community foundation" means a community foundation organized or operating in this state that substantially complies with the national standards for U.S. community foundations established by the National Council on Foundations as determined by the authority in collaboration with the Iowa Council of Foundations.

"Endowment gift" means an irrevocable contribution to a permanent endowment held by an endow Iowa qualified community foundation.

"Permanent endowment fund" means a fund held in an endow Iowa qualifying community foundation to provide benefit to charitable causes in the state of Iowa. Endowed funds are intended to exist in perpetuity, and to implement an annual spend rate not to exceed 5 percent.

"Tax credit" means the amount a taxpayer may claim against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24.
[**ARC 8474B**, IAB 1/13/10, effective 2/17/10; **ARC 0008C**, IAB 2/8/12, effective 3/14/12]

261—47.3(15E) Authorization of tax credits to taxpayers. The authority shall authorize tax credits to qualified taxpayers who provide an endowment gift to an endow Iowa qualified community foundation or a community affiliate organization affiliated with an endow Iowa qualified community foundation for a permanent endowment fund within the state of Iowa in accordance with the following provisions:

47.3(1) Approved tax credits shall be allowed against taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24.

47.3(2) Beginning January 1, 2010, approved tax credits will be equal to 25 percent of a taxpayer's gift to a permanent endowment held in an endow Iowa qualified community foundation. The amount of the endowment gift for which the endow Iowa tax credit is claimed shall not be deductible in determining taxable income for state income tax purposes.

47.3(3) The aggregate amount of tax credits available under this rule is limited according to Iowa Code section 15E.305, subsection 2. The aggregate amount is determined by taking a base authorization amount specified in Iowa Code section 15E.305, subsection 2, paragraph *"a,"* and adding an additional amount to be determined annually by calculating a certain percentage of the state's gambling revenues, as provided in Iowa Code section 99F.11, subsection 3, paragraph *"d,"* subparagraph (3), for the prior fiscal year. For calendar year 2011 and for all subsequent calendar years, the annual base authorization amount of available tax credits is $3.5 million. The additional amount varies each year according to the amount of gambling revenues collected in the prior year. For 2011, the aggregate amount of available tax credits is $4,551,813. The maximum amount of tax credit that an individual taxpayer may claim is limited to 5 percent of the aggregate amount available each year. For 2011, the maximum amount of tax credit available to a single taxpayer is $227,590.65. If the authority receives applications for tax credits in excess of the amount available, the applications shall be prioritized by the date the authority received the applications. If the number of applications exceeds the amount of annual tax credits available, the

authority shall establish a wait list for the next year's allocation of tax credits and applications shall first be funded in the order listed on the wait list.

47.3(4) Any tax credit in excess of the taxpayer's tax liability for the tax year may be credited to the tax liability for the following five years or until depleted, whichever occurs first.

47.3(5) A tax credit shall not be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit.

47.3(6) A tax credit shall not be transferable to any other taxpayer.

[**ARC 8474B**, IAB 1/13/10, effective 2/17/10; **ARC 0008C**, IAB 2/8/12, effective 3/14/12]

261—47.4(15E) Distribution process and review criteria. The authority shall develop and make available a standardized application pertaining to the allocation of endow Iowa tax credits.

47.4(1) Twenty-five percent of the annual amount available for tax credits shall be reserved for those permanent endowment gifts made to community affiliate organizations. If by September 1 of any year the entire 25 percent reserved for permanent endowment gifts corresponding to community affiliate organizations is not allocated, the amount remaining shall be available for other applicants.

47.4(2) Ten percent of the annual amount available for tax credits shall be reserved for those permanent endowment gifts totaling $30,000 or less. If by September 1 of any year the entire 10 percent reserved for permanent endowment gifts totaling $30,000 or less is not allocated, the amount remaining shall be available for other applicants.

47.4(3) Applications will be accepted and awarded on an ongoing basis. The authority will make public by June 1 and December 1 of each calendar year the total number of requests for tax credits and the total amount of requested tax credits that have been submitted and awarded.

[**ARC 8474B**, IAB 1/13/10, effective 2/17/10; **ARC 0008C**, IAB 2/8/12, effective 3/14/12]

261—47.5(15E) Reporting requirements. By January 31 of each calendar year, the authority shall publish an annual report of the activities conducted pursuant to these rules during the previous calendar year and shall submit the report to the governor and general assembly. The annual report shall include the information required by Iowa Code section 15.104(9)*"h."*

[**ARC 8474B**, IAB 1/13/10, effective 2/17/10; **ARC 0008C**, IAB 2/8/12, effective 3/14/12]

These rules are intended to implement Iowa Code sections 15E.301 to 15E.306 as amended by 2011 Iowa Acts, Senate File 302.

[Filed 11/20/03, Notice 10/1/03—published 12/24/03, effective 1/28/04]
[Filed 10/21/05, Notice 8/3/05—published 11/9/05, effective 12/14/05]
[Filed ARC 8474B (Notice ARC 8228B, IAB 10/7/09), IAB 1/13/10, effective 2/17/10]
[Filed ARC 0008C (Notice ARC 9748B, IAB 9/7/11), IAB 2/8/12, effective 3/14/12]

CHAPTER 65
BROWNFIELD AND GRAYFIELD REDEVELOPMENT

261—65.1(15) Purpose. The brownfield redevelopment program is designed to provide financial and technical assistance for the acquisition, remediation, or redevelopment of brownfield sites. The redevelopment tax credit program for brownfields and grayfields is designed to provide financial assistance for the acquisition, remediation, or redevelopment of brownfield and grayfield sites.
[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.2(15) Definitions. As used in these rules, unless the context otherwise requires, the definitions in Iowa Code section 15.292 shall apply to this chapter. The following definitions shall also apply:

"Acquisition" means the purchase of brownfield or grayfield property.

"Advisory council" means the brownfield redevelopment advisory council as established in Iowa Code section 15.294 consisting of five members.

"Authority" means the economic development authority.

"Board" means the economic development authority board pursuant to 2011 Iowa Code Supplement section 15.102.

"Brownfield site" means an abandoned, idled, or underutilized industrial or commercial facility where expansion or redevelopment is complicated by real or perceived environmental contamination. A brownfield site includes property contiguous with the property on which the individual or commercial facility is located. A brownfield site shall not include property which has been placed, or is proposed for placement, on the national priorities list established pursuant to the federal Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), 42 U.S.C. 9601 et seq.

"CERCLA" means Comprehensive Environmental Response, Compensation, and Liability Act as defined at 42 U.S.C. 9601 et seq.

"Characterization" means determination of both the nature and extent of contamination in the various media of the environment.

"Community" means a city or county, or an entity established pursuant to Iowa Code chapter 28E.

"Contaminant" means any hazardous substance found in the various media of the environment.

"Council" means the brownfield redevelopment advisory council, as established in Iowa Code section 15.294.

"Fund" means the brownfield redevelopment fund established pursuant to Iowa Code section 15.293.

"Grant" means the donation or contribution of funds with no expectation or requirement that the funds be repaid.

"Grayfield site" means an industrial or commercial property meeting all of the following requirements:

1. Infrastructure on the property is outdated or prevents an efficient use of the property, including vacant, blighted, obsolete, or otherwise underutilized property.
2. Property improvements and infrastructure are at least 25 years old and one or more of the following conditions exist:

- Thirty percent or more of a building located on the property is available for occupancy and has been vacated or unoccupied for at least 12 months;
- Assessed value of improvements on the property has decreased by 25 percent or more;
- The property is used as a parking lot;
- Improvements on the property no longer exist.

"Green development" means development which meets or exceeds the sustainable design standards as established by the state building code commissioner pursuant to Iowa Code section 103A.8B.

"Hazardous substance" means "hazardous substance" as defined in 567—Chapter 137 and includes petroleum substances not addressed in 567—Chapter 135.

"Loan" means an award of assistance with the requirement that the award be repaid, and with term, interest rate, and any other conditions specified as part of the award. A deferred loan is one for which

the payment of principal or interest, or both, is not required for some specified period. A forgivable loan is one for which repayment is eliminated in part or entirely if the borrower satisfies specified conditions. A loan guarantee is a third-party commitment to repay all or a portion of the loan in the event that the borrower defaults on the loan.

"Qualifying investment" means costs that are directly related to a qualifying redevelopment project and that are incurred after the project has been registered and approved by the board. "Qualifying investment" only includes the purchase price, the cleanup costs, and the redevelopment costs.

"Qualifying investor" means an applicant who has been accepted by the department to receive a redevelopment tax credit.

"Qualifying redevelopment project" means a brownfield or grayfield site being redeveloped or improved by the property owner. "Qualifying redevelopment project" does not include a previously remediated or redeveloped brownfield site.

"Redevelopment" means projects that result in the elimination of blighting characteristics as defined by Iowa Code section 403.2.

"Remediation" includes characterization, risk assessment, removal and cleanup of environmental contaminants located on and adjacent to a brownfield site. Funding awards used for remediation must comply with appropriate Iowa department of natural resources requirements and guidelines.

"Risk evaluation" means assessment of risks to human health and environment by way of guidelines established in 567—Chapter 137.

"Sponsorship" means an agreement between a city or county and an applicant for assistance under the brownfield redevelopment program in which the city or county agrees to offer assistance or guidance to the applicant. Sponsorship is not required if the applicant is a city or county.

"Sustainable design" means construction design intended to minimize negative environmental impacts and to promote the health and comfort of building occupants including, but not limited to, measures to reduce consumption of nonrenewable resources, minimize waste, and create healthy, productive environments. Sustainable design standards are also known as green building standards pursuant to Iowa Code section 103A.8B.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.3(15) Eligible applicants. To be eligible to apply for program assistance, an applicant must meet the following eligibility requirements:

65.3(1) *Site owner.* A person owning a site is an eligible applicant if the site for which assistance is sought meets the definition of a brownfield or grayfield site. The brownfield redevelopment program requires that an applicant has secured a sponsor prior to applying for program assistance. Sponsorship is encouraged but not required for the redevelopment tax credit program for brownfields and grayfields.

65.3(2) *Nonowner of site.* A person who is not an owner of a site is an eligible applicant if the site meets the definition of a brownfield or grayfield site. The brownfield redevelopment program requires that an applicant has secured a sponsor prior to applying for program assistance. Prior to applying for financial assistance under the brownfield redevelopment program, an applicant who is not an owner of a site shall enter into an agreement with the owner of the brownfield site for which financial assistance is sought. The agreement shall at a minimum include:

a. The total cost for remediating the site.

b. Agreement that the owner shall transfer title of the property to the applicant upon completion of the remediation of the property. Title transfer is not required when the applicant is the owner of the property and no title transfer occurs.

c. Agreement that upon the subsequent sale of the property by the applicant to a person other than the original owner, the original owner shall receive not more than 75 percent of the estimated total cost of the remediation, acquisition or redevelopment.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.4(15) Eligible forms of assistance and limitations.

65.4(1) *Financial assistance.* Eligible forms of financial assistance include grants, interest-bearing loans, forgivable loans, loan guarantees, tax credits, and other forms of assistance under the brownfield

redevelopment program and the redevelopment tax credit program for brownfields and grayfields established in 2011 Iowa Code Supplement sections 15.292 and 15.293A.

65.4(2) *Other forms of assistance.* The authority may provide information on alternative forms of assistance.

65.4(3) *Limitation on amount.* An applicant shall not receive financial assistance of more than 25 percent of the agreed-upon estimated total cost of remediation, acquisition or redevelopment. This limitation does not apply to assistance provided in the form of tax credits pursuant to subrule 65.11(4).

65.4(4) *Exclusions.* Program funds shall not be used for the remediation of contaminants being addressed under Iowa's leaking underground storage tank (UST) program. However, a site's being addressed under the UST program does not necessarily exclude that site from being addressed under the Iowa brownfield redevelopment Act if other nonpetroleum contaminants or petroleum substances not addressed under 567—Chapter 135 are present.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.5(15) Repayment to economic development authority. Under the brownfield redevelopment program only, upon the subsequent sale of the property by an applicant to a person other than the original owner, the applicant shall repay the authority for financial assistance received by the applicant. The repayment shall be in an amount equal to the sales price less the amount paid to the original owner pursuant to the agreement between the applicant and the original owner. The repayment amount shall not exceed the amount of financial assistance actually disbursed to the applicant by the authority.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.6(15) Application and award procedures.

65.6(1) Subject to availability of funds, applications to the brownfield redevelopment program will be reviewed and rated by economic development authority staff and by the advisory council on an annual basis. Brownfield redevelopment funds will be awarded on a competitive basis.

65.6(2) Subject to availability of funds, applications to the redevelopment tax credit program for brownfields and grayfields will be reviewed by economic development authority staff and the advisory council on a monthly basis.

65.6(3) Applications will be reviewed by staff for completeness and eligibility. If additional information is required, the applicant shall be provided with notice, in writing, to submit additional information. Recommendations from the advisory council will be submitted to the board. The board may approve, deny or defer an application.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.7(15) Application.

65.7(1) Every application for assistance shall include evidence of sponsorship and any other information the authority deems necessary in order to process and review the application. An application shall be considered received by the authority only when the authority deems it to be complete. Applications for assistance shall also include the following information:

a. A business plan. The business plan should, at a minimum, include a remediation plan, a project contact/applying agency, a project overview (which would include the background of the project area, goals and objectives of the project, and implementation strategy), and a project/remediation budget.

b. A statement of purpose describing the intended use of and proposed repayment schedule for any financial assistance received by the applicant.

65.7(2) The authority shall accept and review applications in conjunction with the council and the board. The council shall consider applications in the order complete applications are received and make application recommendations to the board. The board shall approve or deny applications.

65.7(3) Upon review of the application for the redevelopment tax credit program for brownfields and grayfields, the authority may register the project under the program. If the authority registers the project, it shall, in conjunction with the council and the board, make a preliminary determination as to the maximum amount of the tax credit for which the investor qualifies. After registering the project, the authority shall issue a letter notifying the investor of successful registration under the program. The letter

shall include the maximum amount of tax credit for which the investor has received preliminary approval and shall state that the amount is a preliminary determination only. The preliminary determination is not a contract, contract term, promise, guarantee, assurance, or representation of the actual tax credit the investor will receive or should expect to receive. The preliminary determination is a nonbinding figure, provided purely for the investor's and the authority's information and convenience, based on the authority's existing understanding and estimates related to the project. The amount of tax credit included on a certificate issued pursuant to this subrule shall be contingent upon completion of the requirements of subrules 65.7(4) to 65.7(6) and shall be based solely on completion and compliance with all terms and conditions of the contract pursuant to this rule, rule 261—65.10(15), and 2011 Iowa Code Supplement sections 15.293A and 15.293B.

65.7(4) Approved applicants shall enter into an agreement with the authority. The agreement for the redevelopment tax credit program for brownfields and grayfields shall specify the requirements necessary in order to receive tax credit and the maximum amount of tax credit available. The agreement for the brownfield redevelopment program shall specify the requirements necessary in order to receive benefits under the program.

65.7(5) Upon completion of a registered project under the redevelopment tax credit program for brownfields and grayfields, an audit of the project's qualifying expenses shall be completed by an independent certified public accountant licensed in the state of Iowa and shall be submitted to the authority.

65.7(6) Upon written notification of project completion from the investor, the authority will review the independent audit, verify the amount of the qualifying investment and issue a redevelopment tax credit certificate to the investor in the amount of the tax credit for which the investor is entitled under its contract with the authority.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.8(15) Application forms. Application forms for the brownfield redevelopment program and the redevelopment tax credit program for brownfields and grayfields shall be available upon request from Economic Development Authority, 200 East Grand Avenue, Des Moines, Iowa 50309. The authority may provide technical assistance as necessary to applicants. Authority staff may conduct on-site evaluations of proposed activities.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.9(15) Application review criteria. Brownfield redevelopment funds will be awarded on a competitive basis. Applications will be reviewed and prioritized based on the following criteria:

1. Whether the project meets the definition of a brownfield site.
2. Whether alternative forms of assistance have been explored and used by the applicant.
3. The level of distress or extent of the problem on the site has been identified.
4. Whether the site is on or proposed to be added to the U.S. Environmental Protection Agency's list of CERCLA sites.
5. The degree to which awards secured from other sources are committed to the subject site.
6. The leveraging of other public and private resources beyond the 75 percent minimum required.
7. Type and terms of assistance requested.
8. Rationale that the project serves a public purpose.
9. The level of economic and physical distress within the project area.
10. Past efforts of the community/owner to resolve the problem.
11. Ability of the applicant to outline the goals and objectives of the project and describe the overall strategy for achieving the goals and objectives.
12. Ancillary off-site development as a result of site remediation.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09]

261—65.10(15) Administration of awards.

65.10(1) A contract shall be executed between the recipient and the authority. These rules and applicable state laws and regulations shall be part of the contract.

65.10(2) The recipient must execute and return the contract to the authority within 45 days of transmittal of the final contract from the authority. Failure to do so may be cause for the board to terminate the award.

65.10(3) Certain activities may require that permits or clearances be obtained from other state or local agencies before the activity may proceed. Awards may be conditioned upon the timely completion of these requirements.

65.10(4) Awards may be conditioned upon commitment of other sources of funds necessary to complete the activity.

65.10(5) Awards may be conditioned upon the authority's receipt and approval of an implementation plan for the funded activity.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.11(15) Redevelopment tax credit.

65.11(1) *Purpose.* The purpose of the redevelopment tax credit program is to make tax credits available for a redevelopment project investment. The authority may cooperate with the department of natural resources and local governments in an effort to disseminate information regarding the redevelopment tax credit.

65.11(2) *Eligible applicant.* An individual, partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual may claim a redevelopment tax credit. Once an applicant is deemed eligible, the applicant shall be considered a qualifying investor for a redevelopment tax credit. A city or county may not apply for a redevelopment tax credit.

65.11(3) *Tax credit certificate.*

a. Issuance. The authority shall issue a redevelopment tax credit certificate upon completion of the project and submittal of proof of completion by the qualified investor. The tax credit certificate shall contain the qualified investor's name, address, tax identification number, the amount of the credit, the name of the qualifying investor, any other information required by the department of revenue, and a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred.

b. Acceptance. The tax credit certificate, unless rescinded by the board, shall be accepted by the Iowa department of revenue as payment for taxes imposed pursuant to Iowa Code chapter 422, divisions II, III, and V, and to Iowa Code chapter 432, and for the moneys and credits tax imposed in Iowa Code section 533.329, subject to any conditions or restrictions placed by the board upon the face of the tax credit certificate and subject to the limitations of this rule, for a portion of a taxpayer's equity investment in a qualifying redevelopment project.

c. Transfer. Tax credit certificates issued under this rule may be transferred to any person or entity. Within 90 days of transfer, the transferee shall submit the transferred tax credit certificate to the Iowa department of revenue, including a statement with the transferee's name, tax identification number, address, the denomination that each replacement tax credit certificate is to carry, and any other information required by the Iowa department of revenue.

d. Replacement certificate. Within 30 days of receiving the transferred tax credit certificate and the transferee's statement, the Iowa department of revenue shall issue one or more replacement tax credit certificates to the transferee. Each replacement tax credit certificate must contain the information required for the original tax credit certificate and must have the same expiration date that appeared in the transferred tax credit certificate.

e. Claiming a transferred tax credit. A tax credit shall not be claimed by a transferee until a replacement tax credit certificate identifying the transferee as the proper holder has been issued. The transferee may use the amount of the tax credit transferred against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.329, for any tax year the original transferor could have claimed the tax credit. Any consideration paid or received for the transfer of the tax credit shall not be included or deducted as income under Iowa Code chapter 422, divisions II, III, and V, under Iowa Code chapter 432, or against the moneys and credits tax imposed in Iowa Code section 533.329.

65.11(4) *Amount of tax credit.*

a. Pro rata share. The qualified investor may claim the amount based upon the pro rata share of the qualified investor's earnings from the partnership, limited liability company, S corporation, estate, or trust. Any tax credit in excess of the qualified investor's liability for the tax year is not refundable but may be credited to the tax liability for the following five years or until depleted, whichever is earlier. A tax credit shall not be carried back to a tax year prior to the tax year in which the qualified investor receives the tax credit.

b. Percentage. The amount of the tax credit shall equal one of the following:

(1) Twelve percent of the taxpayer's qualifying investment in a grayfield site.

(2) Fifteen percent of the taxpayer's qualifying investment in a grayfield site if the qualifying redevelopment project meets the requirements of green development as defined in 261—65.2(15).

(3) Twenty-four percent of the taxpayer's qualifying investment in a brownfield site.

(4) Thirty percent of the taxpayer's qualifying investment in a brownfield site if the qualifying redevelopment project meets the requirements of green development as defined in 261—65.2(15).

c. Maximum credit per project. The maximum amount of a tax credit for a qualifying investment in any one qualifying redevelopment project shall not exceed 10 percent of the maximum amount of tax credits available in any one fiscal year pursuant to paragraph 65.11(4)*"d."*

d. Maximum credit total. For the fiscal year beginning July 1, 2009, the maximum amount of tax credits issued by the authority shall not exceed $1 million. For the fiscal year beginning July 1, 2011, and for each subsequent fiscal year, the maximum amount of tax credits issued by the authority shall be an amount determined by the board but not in excess of $5 million.

65.11(5) *Claiming a tax credit.* The qualified investor must attach one or more tax credit certificate(s) to the qualified investor's tax return. A tax credit certificate shall not be used or attached to a return filed for a taxable year beginning prior to July 1, 2009. The tax credit certificate or certificates attached to the qualified investor's tax return shall be issued in the qualified investor's name, expire on or after the last day of the taxable year for which the qualified investor is claiming the tax credit, and show a tax credit amount equal to or greater than the tax credit claimed on the qualified investor's tax return.

65.11(6) *Reduction of tax credit.*

a. Taxes imposed under Iowa Code section 422.11V, less the credits allowed under Iowa Code sections 422.12, 422.33, 422.60, 432.12L, and moneys and credits imposed under Iowa Code section 533.329 shall be reduced by a redevelopment tax credit allowed under Iowa Code sections 15.291 to 15.294.

b. For purposes of individual and corporate income taxes and the franchise tax, the increase in the basis of the redeveloped property that would otherwise result from the qualified redevelopment costs shall be reduced by the amount of the credit computed under this rule.

65.11(7) *Project completion.*

a. An investment shall be deemed to have been made on the date the qualifying redevelopment project is completed. An investment made prior to January 1, 2009, shall not qualify for a tax credit under this rule.

b. A registered project shall be completed within 30 months of the project's approval unless the authority, with the approval of the board, provides additional time to complete the project. A project shall not be provided more than 12 months of additional time. If the registered project is not completed within the time required, the project is not eligible to claim a tax credit.

c. Failure to comply. If a taxpayer receives a tax credit pursuant to 2011 Iowa Code Supplement section 15.293A, but fails to comply with any of the requirements, the taxpayer loses any right to the tax credit. The Iowa department of revenue shall seek recovery of the value of the credit the qualified investor received.

65.11(8) *Tax credit carryover.* If the maximum amount of tax credits available has not been issued at the end of the fiscal year, the remaining tax credit amount may be carried over to a subsequent fiscal year or the authority may prorate the remaining credit amount among other eligible applicants.

65.11(9) *Authority registration and authorization.* The authority shall develop a system for registration and authorization of tax credits. The authority shall control distribution of all tax credits

distributed to investors, including developing and maintaining a list of tax credit applicants from year to year to ensure that if the maximum aggregate amount of tax credits is reached in one year, an applicant can be given priority consideration for a tax credit in an ensuing year.

65.11(10) *Other financial assistance considerations.* If a qualified investor has also applied to the authority, the board, or any other agency of state government for additional financial assistance, the authority, the board, or the agency of state government shall not consider the receipt of a tax credit issued pursuant to this rule when considering the application for additional financial assistance.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

261—65.12(15) Review, approval, and repayment requirements of redevelopment tax credit.

65.12(1) A qualified investor seeking to claim a tax credit pursuant to 2011 Iowa Code Supplement sections 15.293A and 15.293B shall apply to the authority, and applications shall be reviewed by the council as established in 2011 Iowa Code Supplement section 15.294. The council shall recommend to the board the tax credit amount available for each qualifying redevelopment project.

65.12(2) A qualified investor shall provide to the authority, the council and the board all of the following:

a. Information showing the total costs of the qualifying redevelopment project, including the costs of land acquisition, cleanup, and redevelopment.

b. Information about the financing sources of the investment which is directly related to the qualifying redevelopment project for which the taxpayer is seeking approval for a tax credit, as provided in 2011 Iowa Code Supplement section 15.293A.

[**ARC 7844B**, IAB 6/17/09, effective 7/22/09; **ARC 9746B**, IAB 9/7/11, effective 8/19/11; **ARC 0007C**, IAB 2/8/12, effective 3/14/12]

These rules are intended to implement 2011 Iowa Code Supplement sections 15.291 to 15.295.

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CHAPTER 115
TAX CREDITS FOR INVESTMENTS IN QUALIFYING BUSINESSES AND COMMUNITY-BASED SEED CAPITAL FUNDS

261—115.1(84GA,SF517) Tax credits for investments in qualifying businesses and community-based seed capital funds. Tax credits for investments in qualifying businesses and community-based seed capital funds may be claimed as provided in this rule.

115.1(1) *Tax credits allowed only after a certain date.* A taxpayer may claim a tax credit under this rule for equity investments in certain qualifying businesses or community-based seed capital funds. Only equity investments made on or after January 1, 2011, qualify for a tax credit under this rule. Equity investments made before that date must be claimed under 123—Chapter 2.

115.1(2) *Investments in qualifying businesses.*

a. A taxpayer may claim a tax credit under this subrule for a portion of the taxpayer's equity investment in a qualifying business if that investment was made on or after January 1, 2011.

b. The tax credit may be claimed against the taxpayer's tax liability for any of the following taxes:

(1) The personal net income tax imposed under Iowa Code chapter 422, division II.

(2) The business tax on corporations imposed under Iowa Code chapter 422, division III.

(3) The franchise tax on financial institutions imposed under Iowa Code chapter 422, division V.

(4) The tax on the gross premiums of insurance companies imposed under Iowa Code chapter 432.

(5) The tax on moneys and credits imposed under Iowa Code section 533.329.

115.1(3) *Investments in community-based seed capital funds.*

a. A taxpayer may claim a tax credit under this subrule for a portion of the taxpayer's equity investment in a community-based seed capital fund if that investment was made on or after January 1, 2011.

b. The tax credit may be claimed against the taxpayer's tax liability for any of the following taxes:

(1) The personal net income tax imposed under Iowa Code chapter 422, division II.

(2) The business tax on corporations imposed under Iowa Code chapter 422, division III.

(3) The franchise tax on financial institutions imposed under Iowa Code chapter 422, division V.

(4) The tax on gross premiums of insurance companies imposed under Iowa Code chapter 432.

(5) The tax on moneys and credits imposed under Iowa Code section 533.329.

115.1(4) *Amount of tax credit that may be claimed by taxpayer.*

a. The amount of tax credit available to a taxpayer under this rule is equal to 20 percent of the taxpayer's equity investment in either a qualifying business or community-based seed capital fund.

b. The maximum amount of a tax credit for an investment by an investor in any one qualifying business shall be $50,000. Each year, an investor, and all affiliates of that investor, shall not claim tax credits under this rule for more than five different investments in five different qualifying businesses.

c. An investor in a community-based seed capital fund shall receive a tax credit pursuant to this rule only for the investor's investment in the community-based seed capital fund and shall not receive any additional tax credit for the investor's share of investments in a qualifying business made by the community-based seed capital fund or in an Iowa-based seed capital fund which has at least 40 percent of its committed capital subscribed by community-based seed capital funds. However, an investor in a community-based seed capital fund may receive a tax credit under this rule with respect to a separate direct investment made by the investor in the same qualifying business in which the community-based seed capital fund invests.

115.1(5) *Claiming an investment tax credit.* A taxpayer that makes an investment in a qualifying business or community-based seed capital fund and that otherwise meets the requirements of this chapter will receive a board-approved tax credit certificate from the authority. To claim the credit, the taxpayer must attach the certificate to a tax return filed with the department of revenue. For more information on claiming the tax credit, see department of revenue rule 701—42.22(15E,422).

115.1(6) *Tax credits for pass-through entities.* If the taxpayer that is entitled to a tax credit for an investment in a community-based seed capital fund or a qualifying business is a pass-through entity electing to have its income taxed directly to its individual owners, such as a partnership, limited liability

company, S corporation, estate or trust, the pass-through entity must allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro-rata share of the earnings of the entity, and the individual owners may claim their respective credits on their individual income tax returns.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.2(84GA,SF517) Definitions. For purposes of this chapter, unless the context otherwise requires:

"Affiliate" means a spouse, child, or sibling of an investor or a corporation, partnership, or trust in which an investor has a controlling equity interest or in which an investor exercises management control.

"Authority" means the economic development authority created in 2011 Iowa Acts, House File 590.

"Board" means the same as defined in Iowa Code section 15.102 as amended by 2011 Iowa Acts, House File 590, section 3.

"Community-based seed capital fund" means a fund that meets the following criteria:

1. Is organized as a limited partnership or limited liability company;

2. Has, on or after January 1, 2011, a total of capital commitments from both investors and investments in qualifying businesses of at least $125,000, but not more than $3 million. If the fund is either a rural business investment company under the Rural Business Investment Program of the federal Farm Security and Rural Investment Act of 2002 or an Iowa-based seed capital fund with at least 40 percent of its committed capital subscribed by community-based seed capital funds, the fund may have more than $3 million of capital commitments from both investors and investments in qualifying businesses; and

3. Has no fewer than five investors that are not affiliates, with no single investor and affiliates of that investor together owning a total of more than 25 percent of the ownership interests outstanding in the fund.

"Controlling equity interest" means ownership of more than 50 percent of the outstanding equity interests of a corporation, partnership, limited liability company or trust.

"Equity" means common or preferred corporate stock or warrants to acquire such stock, membership interests in limited liability companies, partnership interests in partnerships, or near equity. Equity shall be limited to securities or interests acquired only for cash and shall not include securities or interests acquired at any time for services, contributions of property other than cash, or any other non-cash consideration.

"Investor" means a person that makes a cash investment in a community-based seed capital fund or in a qualifying business on or after January 1, 2011. "Investor" does not include a person that holds at least a 70 percent ownership interest as an owner, member, or shareholder in a qualifying business for investments made on or after January 1, 2011.

"Management control" means holding more than 50 percent of the voting power on any board of directors or trustees, any management committee, or any other group managing a corporation, partnership, limited liability company or trust.

"Near equity" means debt that may be converted to equity at the option of the debt holder, and royalty agreements.

"Person" means an individual, corporation, limited liability company, business trust, estate, trust, partnership or association, or any other legal entity.

"Qualifying business" means a business that meets the following criteria:

1. The principal business operations of the business are located in the state of Iowa;

2. The business has been in operation for six years or less, as measured from the date of the investment for which a credit is claimed;

3. The business has an owner who has successfully completed one of the following:

- An entrepreneurial venture development curriculum, such as programs developed by a John Pappajohn Entrepreneurial Center, or a holistic training program recognized by the Iowa economic development authority which generally encompasses the following areas: entrepreneurial training,

management team development, intellectual property management, market research and analysis, sales and distribution development, financial planning, and management and strategic planning;

- Three years of relevant business experience;
- A four-year college degree in business management, business administration or a related field;
- Other training or experience sufficient to increase the probability of success of the qualifying business;

4. The business is not a business engaged primarily in retail sales, real estate or the provision of health care services or other services requiring a professional license;

5. The business does not have a net worth that exceeds $5 million as of the date of the investment for which the credit is claimed; and

6. Within 24 months from the first date on which the equity investments qualifying for investment tax credits have been made, the business shall have secured total equity or near equity financing equal to at least $250,000.

"Services requiring a professional license" includes but is not limited to the professions listed in Iowa Code section 496C.2.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.3(84GA,SF517) Cash investments required. In order to qualify for a tax credit under this chapter, the taxpayer's investment must be made in the form of cash to purchase equity in a qualifying business or in a community-based seed capital fund.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.4(84GA,SF517) Applying for an investment tax credit.

115.4(1) A taxpayer that desires to receive an investment tax credit for an equity investment in a qualifying business or community-based seed capital fund shall submit an application to the board for approval and provide such other information and documentation as may be requested by the board. Application forms for the investment tax credit may be obtained by contacting the Economic Development Authority, 200 East Grand Avenue, Des Moines, Iowa 50309. The telephone number is (515)725-3000.

115.4(2) Application forms may also be obtained by contacting a Small Business Development Center in the applicant's geographic location. The authority will coordinate with Small Business Development Centers throughout the state to provide uniform application forms to Small Business Development Centers and to disseminate information regarding the investment tax credits. The authority will provide a summary of the investment tax credits to Small Business Development Centers by either supplying the Small Business Development Centers with a copy of these rules or delivering substantially similar information in any other format approved by the authority. The authority will make itself accessible to Small Business Development Centers for assistance with questions concerning completion of applications or any other questions pertaining to the investment tax credits available under this chapter.

115.4(3) Applications shall be date- and time-stamped by the authority in the order in which such applications are received. Applications for the investment tax credit shall be accepted by the authority until March 31 of the year following the calendar year in which the taxpayer's equity investment was made.

EXAMPLE 1: A taxpayer makes an equity investment in a qualifying business on December 31, 2011. The taxpayer has until March 31, 2012, to apply to the authority for an investment tax credit.

EXAMPLE 2: A taxpayer makes an equity investment in a qualifying business on July 1, 2012. The taxpayer has until March 31, 2013, to apply to the authority for an investment tax credit.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.5(84GA,SF517) Verification of qualifying businesses and community-based seed capital funds.

115.5(1) *Qualifying businesses.*

a. Within 180 days from the first date on which the equity investments qualifying for investment tax credits have been made (or, for investments made during the 2011 calendar year, not later than June 30, 2012), a qualifying business shall provide to the authority the following information as a prerequisite to the authority's issuance of any investment tax credits to investors in such qualifying business:

(1) A signed statement, from an officer, director, manager, member, or general partner of the qualifying business, that contains a description of the general nature of its business operations, the location of the principal business operations, the date on which the business was formed, and the date on which the business commenced operations;

(2) A balance sheet, certified by the chief executive officer and the chief financial officer of the qualifying business, that reflects the qualifying business's assets, liabilities and owners' equity as of the close of the most recent month or quarter;

(3) A signed statement, from an owner of the business, that describes the manner in which such owner satisfies one of the training requirements set forth in the definition of a qualifying business under rule 261—115.2(84GA,SF517);

(4) A signed statement, from an officer, director, manager, member or general partner of the qualifying business, that states the names, addresses, shares or equity interests issued, consideration paid for the shares or equity interests, and the amounts of any tax credits of all shareholders or equity holders who may initially qualify for the tax credits and the earliest year in which the tax credits may be redeemed. The statement shall contain a commitment by the qualifying business to amend its statement as may be necessary from time to time to reflect new equity interests or transfers in equity among current equity holders or as any other information on the list may change; and

(5) A certificate of existence of a business plan for the qualifying business which details the business's growth strategy, management team, production/management plan, marketing plan, financial plan and other standard elements of a business plan.

b. Upon the authority's receipt of the information and documentation necessary to demonstrate satisfaction of the criteria set forth herein, the authority shall, within a reasonable period of time, determine whether a business is a qualifying business. If the authority verifies that the business is a qualifying business, the authority shall register the qualifying business on a registry of such qualifying businesses. The authority shall maintain the registry and use it to authorize the issuance of further investment tax credits to taxpayers who make equity investments in qualifying businesses registered with the authority. The authority shall issue written notification to the qualifying business and the applicant that such business has been registered as a qualifying business with the authority for the purpose of issuing investment tax credits but that such registration is subject to removal and rescission under rule 261—115.9(84GA,SF517) for any failure of the business to continuously satisfy the requirements necessary for verification and registration as a qualifying business.

115.5(2) *Community-based seed capital funds.*

a. Within 180 days from the first date on which the equity investments qualifying for investment tax credits have been made (or, for investments made during the 2011 calendar year, not later than June 30, 2012), a community-based seed capital fund shall provide to the authority information as a prerequisite to the authority's issuance of investment tax credits to investors in such community-based seed capital fund. A community-based seed capital fund cannot invest in the Iowa fund of funds organized by the Iowa capital investment corporation under Iowa Code section 15E.65 but may invest up to 60 percent of its committed capital in an Iowa-based seed capital fund with at least 40 percent of its committed capital subscribed by community-based seed capital funds. The following information must be provided:

(1) A copy of the fund's certificate of limited partnership, limited partnership agreement, articles of organization or operating agreement, or any combination thereof, certified by the chief executive officer of the community-based seed capital fund.

(2) A signed statement, from an officer, director, manager, member or general partner of the fund, that states the total amount of capital contributions or capital commitments from investors, the total number of individual investors that are not affiliates, and the ownership interest of each individual investor in the fund.

(3) A signed statement, from an officer, director, manager, member or general partner of the fund, that states the names, addresses, equity interests issued, consideration paid for the interests and the amounts of any tax credits, of all limited partners or members who may initially qualify for the tax credits, and the earliest year in which the tax credits may be redeemed. The statement shall also contain a commitment by the fund to amend its statement as may be necessary from time to time to reflect new equity interests or transfers in equity among current equity holders or as any other information on the list may change.

b. Upon the authority's receipt of the information and documentation necessary to demonstrate a community-based seed capital fund's satisfaction of the criteria set forth herein, the board shall, within a reasonable period of time, determine whether a fund is a community-based seed capital fund. If the authority verifies that the fund is a community-based seed capital fund, the authority shall register the community-based seed capital fund on a registry of such community-based seed capital funds. The authority shall maintain the registry and use it to authorize the issuance of further investment tax credits to taxpayers that make equity investments in the community-based seed capital funds registered with the authority. The authority shall issue written notification to the community-based seed capital fund and the applicant that such fund has been registered as a community-based seed capital fund with the authority for the purpose of issuing investment tax credits but that such registration is subject to removal and rescission under rule 261—115.9(84GA,SF517) for any failure of the community-based seed capital fund to continuously satisfy the requirements necessary for verification and registration as a community-based seed capital fund.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.6(84GA,SF517) Approval, issuance and distribution of investment tax credits.

115.6(1) *Approval by the board.* Upon verification and registration by the authority of a qualifying business or community-based seed capital fund and approval of the taxpayer's application, the board will approve the issuance of a tax credit certificate to the taxpayer applying for the tax credit.

115.6(2) *Issuance by the authority.* Upon approval by the board, the authority shall issue a tax credit certificate to the applicant, provided, however, that such tax credit certificate shall be subject to rescission pursuant to rule 261—115.9(84GA,SF517).

115.6(3) *Preparation of certificate.* The tax credit certificate shall be prepared by the authority in a form approved by the board and shall contain the taxpayer's name, address, and tax identification number, the amount of credit, the name of the qualifying business or community-based seed capital fund, the year in which the credit may be redeemed and any other information that may be required by the department of revenue. In addition, the tax credit certificate shall contain the following statement:

> Neither the authority nor the board has recommended or approved this investment or passed on the merits or risks of such investment. Investors should rely solely on their own investigation and analysis and seek investment, financial, legal and tax advice before making their own decision regarding investment in this enterprise.

115.6(4) *Maximum aggregate limitation.* The aggregate amount of tax credits issued pursuant to this chapter shall not exceed the amount allocated by the board pursuant to Iowa Code section 15.119, subsection 2. For fiscal year 2012 and all subsequent fiscal years, that amount is $2 million.

If, during any fiscal year during which tax credits are to be issued under this chapter, applications totaling more than the maximum aggregate amount are received and approved, the applications will be carried forward and prioritized to receive tax credit certificates on a first-come, first-served basis in subsequent fiscal years.

When carrying forward and prioritizing such applications, the authority shall (1) issue tax credit certificates to the taxpayers for such carryover tax credits before issuing any new tax credits to later

applicants, and (2) apply the aggregate amount of the credits carried over against the total amount of tax credits to be issued during the subsequent fiscal year before approving or issuing additional tax credits.
[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.7(84GA,SF517) Claiming the tax credits. To claim a tax credit under this chapter, a taxpayer must attach to that taxpayer's tax return a certificate issued pursuant to this chapter when the return is filed with the department of revenue. For more information on claiming tax credits, see department of revenue rule 701—42.22(15E,422).
[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.8(84GA,SF517) Notification to the department of revenue. Upon the issuance and distribution of investment tax credits for a tax year, the authority shall promptly notify the department of revenue by providing copies of the tax credit certificates issued for such tax year to the department of revenue. Such notification shall also include, but not be limited to, the aggregate number and amount of tax credits issued for the tax year.
[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.9(84GA,SF517) Rescinding tax credits.

115.9(1) *Rescission of credits for investments in qualifying businesses.*

a. Within 24 months from the first date on which the equity investments qualifying for investment tax credits have been made, a qualifying business shall provide to the authority information and documentation sufficient to demonstrate that the business has secured total equity or near equity financing equal to at least $250,000. Examples of sufficient information and documentation include, but are not limited to, the following:

(1) Corporate, partnership or limited liability company-certified resolutions setting forth the names of individuals or entities making capital contributions and the amounts of such capital contributions;

(2) Certified corporate, partnership, or limited liability company minutes reflecting the names of individuals or entities making capital contributions and the amounts of such capital contributions.

b. On or by the last day of the 24-month period described in paragraph 115.9(1)*"a,"* a qualifying business shall certify to the authority, by a statement signed by an officer, director, member, manager, or general partner of the qualifying business, that it has secured the requisite amount of equity financing required by this rule within the time period prescribed in paragraph 115.9(1)*"a"* and shall recertify to the authority that the qualifying business continues to meet the requirements set forth in subrule 115.5(1).

c. In the event that a qualifying business fails to meet or maintain any requirement set forth in this rule, including, without limitation, timely filing of the certifications described in paragraph 115.9(1)*"b,"* the authority, upon action by the board, shall rescind any tax credit certificates issued to those taxpayers and shall notify the department of revenue that it has done so. A tax credit certificate that has been rescinded by the authority shall be null and void, and the department of revenue will not accept the tax credit certificate. In addition, the authority shall remove the qualifying business from the registry and shall issue written notification of such removal to the qualifying business and the applicants.

115.9(2) *Rescission of credits for investments in community-based seed capital funds.*

a. A community-based seed capital fund shall have invested at least 33 percent of its invested capital in one or more separate qualifying businesses on or by the last day of the 48-month period that commences with the fund's investing activities.

b. On or by the last day of the 48-month period described in paragraph 115.9(2)*"a,"* a community-based seed capital fund shall certify to the board, by a statement signed by an officer, director, member, manager, or general partner of the community-based seed capital fund, that it has met the requirements of this rule within the time period prescribed by this subrule and shall recertify to the board that the community-based seed capital fund continues to meet the requirements set forth in subrule 115.5(2).

c. In the event that a community-based seed capital fund fails to meet or maintain any requirement set forth in this subrule, including, without limitation, timely filing of the certifications described in paragraph 115.9(2)*"b,"* the authority, upon action of the board, shall rescind any tax credit certificates

issued to limited partners or members and shall notify the department of revenue that it has done so. A tax credit certificate that has been rescinded by the authority shall be null and void, and the department of revenue will not accept the tax credit certificate. In addition, the authority shall remove such community-based seed capital fund from the registry and shall issue written notification of such removal to the community-based seed capital fund and the applicants.

d. Notwithstanding paragraphs 115.9(2)*"a"* to *"c,"* a community-based seed capital fund may apply to the authority for a one-year waiver from the requirements of this rule. The authority shall, upon review of a community-based seed capital fund's application for waiver, exercise reasonable discretion in granting or denying such waiver. In the event that the authority grants to a community-based seed capital fund a one-year waiver from the requirements of this rule, the authority shall defer any rescission of the tax credit certificates until the expiration of such one-year waiver period. If the community-based seed capital fund meets the requirements of this rule by the expiration of such one-year waiver period, the tax credit certificates shall not be rescinded. However, the tax credit certificates shall be rescinded at the end of such one-year waiver period if such requirements have not been met.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—115.10(84GA,SF517) Additional information. The authority may at any time request additional information and documentation from a qualifying business or community-based seed capital fund regarding the operations, job creation and economic impact of such qualifying business or community-based seed capital fund, and the authority may use such information in preparing and publishing any reports to be provided to the governor and the general assembly.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

These rules are intended to implement Iowa Code chapter 15E, division V, and 2011 Iowa Acts, Senate File 517.

[Filed ARC 0009C (Notice ARC 9845B, IAB 11/16/11), IAB 2/8/12, effective 3/14/12]

CHAPTER 116
TAX CREDITS FOR INVESTMENTS IN CERTIFIED INNOVATION FUNDS

261—116.1(84GA,SF517) Tax credit for investments in certified innovation funds.

116.1(1) *Tax credit allowed.* For tax years beginning on or after January 1, 2011, a taxpayer may claim a tax credit for a portion of the taxpayer's equity investment in a certified innovation fund. The tax credit may be claimed against the taxpayer's tax liability for any of the following taxes:

a. The personal net income tax imposed under Iowa Code chapter 422, division II.

b. The business tax on corporations imposed under Iowa Code chapter 422, division III.

c. The franchise tax on financial institutions imposed under Iowa Code chapter 422, division V.

d. The tax on the gross premiums of insurance companies imposed under Iowa Code chapter 432.

e. The tax on moneys and credits imposed under Iowa Code section 533.329.

116.1(2) *Treatment of pass-through entities.* If the taxpayer that is entitled to an investment tax credit for an investment in an innovation fund is a pass-through entity electing to have its income taxed directly to its individual owners, such as a partnership, limited liability company, S corporation, estate or trust, the pass-through entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro-rata share of the earnings of the entity, and the individual owners may claim their respective credits on their individual income tax returns.

116.1(3) *Credits for certain investments disallowed.* A taxpayer shall not claim an investment tax credit for an investment in an innovation fund if the taxpayer is a venture capital investment fund allocation manager for the Iowa fund of funds described in Iowa Code section 15E.65, an investor that receives a tax credit for the same investment in a community-based seed capital fund as described in Iowa Code section 15E.45, or an investor that receives a tax credit for the same investment in a qualifying business as described in Iowa Code section 15E.44.

116.1(4) *Cash investments required.* The taxpayer's equity investment must be made in the form of cash to purchase equity in an innovation fund.

116.1(5) *Amount of credit.* The taxpayer may claim a tax credit in an amount equal to 20 percent of the taxpayer's equity investment in a certified innovation fund.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—116.2(84GA,SF517) Definitions. For purposes of this chapter, unless the context otherwise requires:

"Authority" means the economic development authority created in 2011 Iowa Acts, House File 590.

"Board" means the same as defined in Iowa Code section 15.102 as amended by 2011 Iowa Acts, House File 590, section 3.

"Equity" means common or preferred corporate stock or warrants to acquire such stock, membership interests in limited liability companies, partnership interests in partnerships, or near equity. Equity shall be limited to securities or interests acquired only for cash and shall not include securities or interests acquired at any time for services, contributions of property other than cash, or any other non-cash consideration.

"Innovation fund" means a private, early-stage capital fund that has been certified by the board.

"Innovative business" means a business applying novel or original methods to the manufacture of a product or the delivery of a service. "Innovative business" includes but is not limited to a business engaged in advanced manufacturing, biosciences, or information technology.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—116.3(84GA,SF517) Verification of innovation funds.

116.3(1) An innovation fund shall provide to the authority information as a prerequisite to the issuance of any investment tax credits to investors in such innovation funds. The innovation fund must provide this information within 120 days from the first date on which the equity investments qualifying for the investment tax credit have been made (or, for investments made during the 2011 calendar year, by the later of 120 days from the first date on which the investments have been made or March 31, 2012).

116.3(2) Application forms setting forth the information required to verify the eligibility of an innovation fund may be obtained by contacting the Economic Development Authority, 200 East Grand Avenue, Des Moines, Iowa 50309. The telephone number is (515)725-3000. Applications shall be submitted to the authority at the address identified above.

116.3(3) The following information must be submitted to the authority in order for an eligible innovation fund to be verified:

a. A copy of the fund's certificate of limited partnership, limited partnership agreement, articles of organization or operating agreement certified by the chief executive officer of the innovation fund.

b. A signed statement, from an officer, director, manager, member or general partner of the fund, stating the following:

(1) That the fund will make investments in promising early-stage companies which have a principal place of business in the state.

(2) That the fund proposes to make investments in innovative businesses which have a principal place of business in the state.

(3) That the fund seeks to secure private funding sources for investment in such businesses.

116.3(4) Upon the authority's receipt of the information and documentation necessary to demonstrate satisfaction of the criteria set forth herein, the authority shall, within a reasonable period of time, determine whether a certification will be issued for the innovation fund. If the authority certifies the innovation fund, the authority shall register the fund on a registry that shall be maintained by the authority. The authority shall use the registry to authorize the issuance of further investment tax credits to taxpayers who make equity investments in the innovation funds registered with the authority. The authority shall issue written notification to the innovation fund that the fund has been registered as an innovation fund with the authority for the purpose of issuing investment tax credits.
[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—116.4(84GA,SF517) Application for the investment tax credit. Upon verification and registration by the authority of an innovation fund, a taxpayer who desires to receive an investment tax credit for an equity investment in an innovation fund must submit an application to the authority for approval by the board and provide such other information and documentation as may be requested by the authority. Application forms for the investment tax credit may be obtained by contacting the Economic Development Authority, 200 East Grand Avenue, Des Moines, Iowa 50309. Applications shall be submitted to the authority at the address identified above. Each application shall be date- and time-stamped by the authority in the order in which such applications are received. Applications for the investment tax credit shall be accepted by the authority until March 31 of the year following the calendar year in which the taxpayer's equity investment is made.
[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—116.5(84GA,SF517) Approval, issuance and distribution of investment tax credits.

116.5(1) *Approval and issuance.* Upon verification and registration by the authority of an innovation fund, the authority, upon approval by the board, shall issue a tax credit certificate to the applicant. Applicants shall receive tax credit certificates on a first-come, first-served basis until the maximum aggregate amount of credits authorized for issuance has been reached for any fiscal year.

116.5(2) *Carry forward.* If, during any fiscal year during which tax credits are to be issued under this chapter, applications totaling more than the maximum aggregate amount are received and approved, the applications will be carried forward and prioritized to receive tax credit certificates on a first-come, first-served basis in subsequent fiscal years.

When carrying forward and prioritizing such applications, the authority shall (1) issue tax credit certificates to the taxpayers for such carryover tax credits before issuing any new tax credits to later applicants, and (2) apply the aggregate amount of the credits carried over against the total amount of tax credits to be issued during the subsequent fiscal year before approving or issuing additional tax credits.

116.5(3) *Preparation of the certificate.* The tax credit certificate shall be in a form approved by the authority and shall contain the taxpayer's name, address, and tax identification number, the amount of credit, the name of the innovation fund, the year in which the credit may be redeemed and any other

information that may be required by the department of revenue. In addition, the tax credit certificate shall contain the following statement:

> Neither the authority nor the board has recommended or approved this investment or passed on the merits or risks of such investment. Investors should rely solely on their own investigation and analysis and seek investment, financial, legal and tax advice before making their own decision regarding investment in this enterprise.

116.5(4) *Credit amount.* A tax credit for investment in an innovation fund is equal to 20 percent of the taxpayer's equity investment in the fund.

116.5(5) *Maximum aggregate limitation.* The maximum aggregate amount of tax credits issued pursuant to this chapter shall not exceed the amount allocated by the board pursuant to Iowa Code section 15.119, subsection 2. For fiscal year 2012 and all subsequent fiscal years, that amount is $8 million.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—116.6(84GA,SF517) Claiming the tax credits. To claim a tax credit under this chapter, a taxpayer must attach to that taxpayer's tax return a certificate issued pursuant to this chapter when the return is filed with the department of revenue. For more information on claiming tax credits, see department of revenue rule 701—42.22(15E,422).

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—116.7(84GA,SF517) Notification to the department of revenue. Upon the issuance and distribution of investment tax credits for a tax year, the authority shall promptly notify the department of revenue by providing copies of the tax credit certificates issued for such tax year to the department of revenue. Such notification shall also include, but not be limited to, the aggregate number and amount of tax credits issued for the tax year.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

261—116.8(84GA,SF517) Additional information. The authority may at any time request additional information and documentation from an innovation fund regarding the operations, job creation and economic impact of the fund, and the authority may use such information in preparing and publishing any reports to be provided to the governor and the general assembly.

[**ARC 0009C**, IAB 2/8/12, effective 3/14/12]

These rules are intended to implement 2011 Iowa Acts, Senate File 517.

[Filed ARC 0009C (Notice ARC 9845B, IAB 11/16/11), IAB 2/8/12, effective 3/14/12]

CHAPTER 39
HOME PARTNERSHIP PROGRAM

265—39.1(16) Purpose. The primary purpose of the HOME partnership program is to expand or retain the supply of decent and affordable housing for low- and moderate-income Iowans.
[**ARC 8963B**, IAB 7/28/10, effective 7/8/10]

265—39.2(16) Definitions. When used in this chapter, unless the context otherwise requires:

"Accessible" means that the unit meets the construction standards for the rental unit set forth in Chapter 11 of the International Building Code 2009 or, if more stringent, the local building code related to accessibility of rental units.

"Activity" means one or more specific housing activities, projects or programs assisted through the HOME partnership program.

"Administrative plan" means a document that a HOME recipient establishes that describes the operation of a funded activity in compliance with all state and federal requirements.

"CHDO" means a community housing development organization, which is a nonprofit organization registered with the Iowa secretary of state and certified as such by IFA, pursuant to 24 CFR 92.2 (April 1, 1997).

"Consolidated plan" means the state's housing and community development planning document and the annual action plan update approved by HUD.

"Developer" means any individual or entity responsible for initiating and controlling the development process and ensuring that all phases of the development process, or any material portion thereof, are accomplished. The development process applies to transitional housing, rental housing, rehabilitation, rental housing new construction, and homeowner assistance with development subsidies.

"Development subsidies" means financial assistance provided to developers of newly constructed, single-family housing to address the added costs of constructing housing. In such cases, the total cost of development is likely to exceed the sales price or the appraised fair market value of the housing. Additional costs might include labor, materials and equipment; professional design and construction oversight costs; and required third-party energy efficiency verification and certification costs.

"Displaced homemaker" means an individual who (1) is an adult; (2) has not worked full-time/full-year in the labor force for a number of years but has, during such years, worked primarily without remuneration to care for the home and family; and (3) is unemployed or underemployed and is experiencing difficulty in obtaining or upgrading employment.

"Energy Star" means a joint program of the U.S. Environmental Protection Agency and the U.S. Department of Energy that establishes standards and practices to improve energy efficiency.

"Energy Star certification" means a property meets strict guidelines for energy efficiency set by the U.S. Environmental Protection Agency (EPA), making the property 20 to 30 percent more efficient than standard homes. Homes achieve this level of performance through a combination of energy-efficient improvements, including effective insulation systems, high-performance windows, tight construction and ducts, efficient heating and cooling equipment, and Energy Star-qualified lighting and appliances.

"Energy Star rater" means a certified inspector who works closely with the builder throughout the construction process to help determine the needed energy-saving equipment and construction techniques and to conduct required on-site diagnostic testing and inspections to document that the home is eligible to earn the Energy Star certification.

"Extremely low income" means individuals or families whose annual incomes do not exceed 30 percent of the median income for the area, as determined by HUD.

"First-time home buyer" means an individual or an individual and the individual's spouse who have not owned a home during the three-year period before the purchase of a home with HOME assistance, except that an individual who is a displaced homemaker or single parent may not be excluded from consideration as a first-time home buyer on the basis that the individual, while a homemaker, owned a home with the individual's spouse or resided in a home owned by a spouse; and an individual may not be excluded from consideration on the basis that the individual owns or owned, as a principal residence

during the three-year period before purchase of a home with HOME assistance, a dwelling unit whose structure is (1) not permanently affixed to a permanent foundation in accordance with local or other applicable regulations or (2) not in compliance with state, local or model building codes and cannot be brought into compliance with such codes for less than the cost of constructing a permanent structure.

"Gut rehabilitation" means an activity or project that involves the total removal and replacement of all interior (nonstructural) systems, equipment, components or features of a multifamily structure, whereby the existing structure will be reduced down to the basic structure or exterior building shell (e.g., the foundation system; exterior walls; roofs; and interior structural components such as columns, beams, floors and structural bearing walls). "Gut rehabilitation" may also include structural or nonstructural modifications to the exterior of the structure.

"HOME" means the HOME Investment Partnership Program, authorized by the Cranston-Gonzalez National Affordable Housing Act of 1990.

"HUD" means the U.S. Department of Housing and Urban Development.

"IDIS" means the HUD Integrated Disbursement and Information System.

"IFA" means the Iowa finance authority.

"Lead hazard reduction or abatement carrying costs" means the additional costs incurred by lead professionals to ensure that target housing is lead-safe at the completion of rehabilitation. "Lead hazard reduction or abatement carrying costs" includes, but is not limited to, required notifications and reports, lead hazard or abatement evaluations, revisions to project specifications to achieve lead safety, lead hazard reduction or abatement oversight, and clearance testing and final assessment.

"LIHTC" means low-income housing tax credits and federal tax incentives created through the Tax Reform Act of 1986 and allocated through IFA for affordable rental housing development.

"Local financial support" means financial investment by the recipient through the use of the recipient's own discretionary funds that are a permanent financial contribution or commitment applied to and related to the objectives of the housing activity or project assisted through the HOME partnership program and that are used during the same time frame as the requested housing activity or project.

"Local support" means involvement, endorsement and investment by citizens, organizations and the governing body of the local government in which the housing project is located that promote the objectives of the housing activity or projects assisted through the HOME partnership program.

"Low income" means families whose annual incomes do not exceed 80 percent of the median income for the area, as determined by HUD.

"Net proceeds" means the amount determined by calculating the difference between the resale price and the amount of the outstanding principal loan balance owed plus any seller's reasonable and customary closing costs associated with the resale.

"New construction rental units" means the on-site construction or erection of a building, or buildings, for the purpose of providing rental housing units. New construction rental units include conventional, on-site, stick-built construction and on-site erection or fabrication of manufactured housing units or components of units. New construction rental units also include the addition of any rental units outside the existing walls (the building envelope) of an existing building, or buildings, that are part of a rental rehabilitation, renovation or conversion project.

"Program income" means funds generated by a recipient or subrecipient from the use of HOME funds.

"Reasonable and customary closing costs" means:

1. Seller's reasonable and customary closing costs incurred include, but are not limited to: abstract updating, title search fees, deed preparation fees, bringing current the seller's county taxes, and real estate commission fees. Ineligible costs include, but are not limited to: lender discount points, allowances, inspection fees, and buyer closing costs.

2. Buyer's reasonable and customary closing costs incurred include, but are not limited to: lender origination fees, credit report fees, fees for the title evidence or title opinion, fees for recording and filing of legal documents, attorneys' fees, appraisal fees, and required inspection fees. Ineligible costs under this definition include, but are not limited to: prepayment of taxes, prepayment of insurance, and lender discount points.

"Recaptured funds" means HOME funds which are recouped by the recipient when the housing unit assisted by the HOME partnership program home ownership funds does not continue to be the principal residence of the assisted home buyer for the full affordability period required by federal statute.

"Recipient" means the entity under contract with IFA to receive HOME funds and undertake the funded housing activity.

"Repayment" means HOME funds which the recipient must repay to IFA because the funds were invested in a project or activity that is terminated before completion or were invested in a project or activity which failed to comply with federal requirements.

"Single-family unit" means one dwelling unit designated or constructed to serve only one household or family as the primary residence. Single-family units include a detached single unit, condominium unit, cooperative unit, or combined manufactured housing unit and lot.

"Single parent" means an individual who (1) is unmarried or is legally separated from a spouse and (2) is pregnant or has one or more minor children for whom the individual has custody or joint custody.

"Subrecipient" means a public agency or nonprofit organization selected by IFA to administer all or a portion of an activity under the HOME program. "Subrecipient" includes a state recipient pursuant to 24 CFR 92.201(b)(2). A public agency or nonprofit organization that receives HOME funds as a developer or owner of housing is not a subrecipient. The selection of a subrecipient by IFA is not subject to the procurement procedures and requirements under federal or state law. Eligible activities to be administered by a subrecipient are tenant-based rental assistance and home ownership assistance without development subsidies.

"Technical services" means all services that are necessary to carry out individual, scattered site activities including but not limited to: (1) conducting initial inspections, (2) work write-up or project specification development, (3) cost estimate preparation, (4) construction supervision associated with activities that do not require an architect or engineer, (5) lead hazard reduction or lead abatement need determination and oversight, (6) lead hazard reduction or abatement carrying costs, (7) temporary relocation coordination, (8) financing costs such as security agreement preparation and recording or filing fees, (9) processing of individual applications for assistance, (10) income eligibility determination and verification, (11) value determination (new construction) or after rehabilitation value determination (existing structures), and (12) project-specific environmental clearance processes.

"Technical services provision" means the cost to provide other individual housing project-related services such as: (1) financing costs (security agreement preparation, recording and filing fees), (2) processing individual applications for assistance, (3) income eligibility determination and verification, (4) after rehabilitation value determination, and (5) project-specific environmental clearance.

"Very low income" means families whose annual incomes do not exceed 50 percent of the median income for the area, as determined by HUD.

[**ARC 8963B**, IAB 7/28/10, effective 7/8/10; **ARC 9284B**, IAB 12/15/10, effective 1/19/11; **ARC 9764B**, IAB 10/5/11, effective 11/9/11]

265—39.3(16) Eligible applicants. Eligible applicants for HOME assistance include all incorporated cities and all counties within the state of Iowa, nonprofit 501(c) organizations, CHDOs, and for-profit corporations or partnerships.

39.3(1) Any eligible applicant may apply directly to IFA.

39.3(2) Any eligible applicant may apply individually or jointly with another eligible applicant or other eligible applicants.

[**ARC 9284B**, IAB 12/15/10, effective 1/19/11]

265—39.4(16) Eligible activities and forms of assistance.

39.4(1) Eligible activities include transitional housing, tenant-based rental assistance, rental housing rehabilitation (including conversion and preservation), rental housing new construction, home ownership assistance that includes some form of direct subsidy to the home buyer (including development subsidies), and other housing-related activities as may be deemed appropriate by IFA. Assisted housing may be single-family housing or multifamily housing and may be designed for occupancy by homeowners or tenants.

a. Assisted units shall be affordable.

(1) For rental activities, all assisted units shall rent at the lesser of the area fair market rents or a rent that does not exceed 30 percent of 65 percent of the area median family income and, for projects with five or more units, 20 percent of the assisted units shall rent at the lesser of the fair market rent or a rent that does not exceed 30 percent of 50 percent of the area median family income. Assisted units shall remain affordable for a specified period: 20 years for newly constructed units; 15 years for rehabilitated units receiving over $40,000 per unit in assistance; 10 years for rehabilitated units receiving $15,000 to $40,000 per unit in assistance; and 5 years for projects receiving less than $15,000 per unit.

(2) For tenant-based rental assistance, gross rents shall not exceed the jurisdiction's applicable rent standard and shall be reasonable, based on rents charged for comparable, unassisted rental units.

(3) For home ownership assistance, the initial purchase price for newly constructed units or the after rehabilitation value for rehabilitated units shall not exceed the single family mortgage limits under Section 203(b) of the National Housing Act established in February 2008. Assisted units shall remain affordable through recapture with net proceeds or resale provisions for a specified period: 5 years for projects receiving less than $15,000 in assistance per unit; 10 years for projects receiving $15,000 to $40,000 in assistance per unit; and 15 years for projects receiving over $40,000 in assistance per unit.

b. Assisted households shall meet income limits established by federal program requirements.

(1) For rental activities for projects with 35 units or fewer, all assisted units shall be rented to low-income households; at initial occupancy, 90 percent of the units shall be rented to households with incomes at or below 60 percent of the area's median family income and, for projects with 5 or more units, 20 percent of the units shall be rented initially to very low-income households.

(2) For rental activities for projects with 36 units or more, all assisted units shall be rented to low-income households; at initial occupancy and throughout the HOME compliance period, 5 percent of all of the units, assisted or not assisted, in the project shall be rented to extremely low-income households, and the household shall not pay more than the rent established by HUD for extremely low-income households. At initial occupancy, the remainder of the HOME assisted units shall be rented to households with incomes at or below 60 percent of the area's median family income and, for projects with 5 or more units, 20 percent of the units shall be rented initially to very low-income households.

(3) For tenant-based rental assistance, only households with incomes at or below 80 percent of the area median family income shall be assisted; 90 percent of the households served shall have incomes at or below 60 percent of the area's median family income.

(4) For home ownership assistance, only households with incomes at or below 80 percent of the area median family income shall be assisted.

c. Property standards. All newly constructed housing (single-family and multifamily housing) shall be constructed in accordance with any locally adopted and enforced building codes, standards and ordinances. In the absence of locally adopted and enforced building codes, the requirements of the state building code shall apply.

(1) All rental housing involving rehabilitation shall be rehabilitated in accordance with any locally adopted and enforced building or housing codes, standards and ordinances. In the absence of locally adopted and enforced building or housing codes, the requirements of the state building code shall apply.

(2) All single-family housing involving rehabilitation shall be rehabilitated in accordance with any locally adopted building or housing codes, standards and ordinances. In the absence of locally adopted and enforced building or housing codes, the requirements of the most current version of Iowa's Minimum Housing Rehabilitation Standards shall apply (all communities with populations of 15,000 or less).

d. Energy Star. All new construction must obtain Energy Star certification verified by an Energy Star rater.

39.4(2) Eligible forms of IFA assistance to its recipients include grants, interest-bearing loans, non-interest-bearing loans, interest subsidies, deferred payment loans, forgivable loans or other forms of assistance as may be approved by IFA.

39.4(3) For all single-family housing projects or activities assisting homeowners or home buyers, the only form of HOME funds assistance to the end beneficiary is a forgivable loan.

39.4(4) Program income must be returned to IFA except in the following instances:

a. Subrecipients who receive program income shall reduce the HOME draw amount requested by the amount of program income received and must report to IFA the amount and source of the program income.

b. CHDOs that have an IFA-approved reuse plan and a written agreement that specifies that program income may be retained by the CHDO may use program income as CHDO proceeds.

[**ARC 8963B**, IAB 7/28/10, effective 7/8/10; **ARC 9284B**, IAB 12/15/10, effective 1/19/11; **ARC 9802B**, IAB 10/5/11, effective 9/16/11; **ARC 9764B**, IAB 10/5/11, effective 11/9/11; **ARC 0003C**, IAB 2/8/12, effective 1/20/12]

265—39.5(16) Application procedure.

39.5(1) HOME applications shall be reviewed at least annually. IFA reserves the right to withhold funding from the annual HOME competitive cycle to compensate for insufficient number or quality of applications received, to ensure IFA meets its 15 percent CHDO set-aside from HOME funds, to add HOME funds to existing HOME awards within one year of the original award date, to reallocate deobligated or recaptured funds, and to fund projects that are consistent with the Rural Development Section 515 Preservation Demonstration Program. In the event that funds are withheld from the annual competitive cycle, IFA will entertain additional applications, requests for proposals, or other forms of requests as deemed appropriate by IFA.

39.5(2) Joint applications. For applicants requesting funding from both the HOME partnership and low-income housing tax credit (LIHTC) programs, the applicant may request application forms and related materials from the LIHTC program at IFA. IFA will make a joint tax credit and HOME application available to a potential applicant. The applicant must submit to IFA the completed application with required HOME attachments by the deadline established in the application package. An applicant shall meet the requirements of the LIHTC and the HOME program to receive an award of HOME funds.

a. IFA shall appoint a joint review team to discuss and review applications for HOME and LIHTC funds and any other funding sources. Staff for each program may communicate frequently regarding common projects. Information contained in the joint application will be shared with each program.

b. HOME staff shall review applications for eligibility and for activity threshold requirements. The joint review team shall meet to compare and discuss each common project. Final award decisions regarding funding recommendations will be made in accordance with IFA's qualified allocation plan (scoring and set-asides) and the HOME application requirements. Staff for each program will make recommendations for funding to the IFA board of directors. A decision by one program does not bind the other program to fund a project.

c. An applicant for the HOME partnership program must meet the threshold requirements outlined in rule 265—39.6(16).

[**ARC 9284B**, IAB 12/15/10, effective 1/19/11]

265—39.6(16) Application requirements. To be considered for HOME assistance, an application shall meet the following threshold criteria.

39.6(1) The application shall propose a housing activity consistent with the HOME fund purpose and eligibility requirements and the state consolidated plan.

39.6(2) The application shall document the applicant's capacity to administer the proposed activity. Such documentation may include evidence of successful administration of prior housing activities. IFA reserves sole discretion to deny funding to an applicant that has failed to comply with federal or state requirements in the administration of a previous project funded by the state of Iowa or that failed to comply with federal requirements in the administration of a previous project funded in any other state. Documentation of the ability of the applicant to provide technical services and the availability of certified lead professionals and contractors either trained in safe work practices or certified as abatement contractors may also be required as applicable to the HOME fund activity.

39.6(3) The application shall provide evidence of the need for the proposed activity, the potential impact of the proposed activity, the feasibility of the proposed activity, and the impact of additional housing resources on the existing related housing market.

39.6(4) The application shall demonstrate local support for the proposed activity.

39.6(5) The application shall show that a need for HOME assistance exists after all other financial resources have been identified and secured for the proposed activity.

39.6(6) The application shall include a certification that the applicant will comply with all applicable state and federal laws and regulations.

39.6(7) Maximum per-unit subsidy amount and subsidy layering. The following shall apply to all applications:

a. The total amount of HOME funds awarded on a per-unit basis may not exceed the per-unit dollar limitations established under Section 221(d)(3)(ii) of the National Housing Act (12 U.S.C. 17151(d)(3)(ii)) for elevator-type projects that apply to the area in which the housing is located.

b. IFA shall evaluate the project in accordance with subsidy layering guidelines adopted for this purpose.

c. The total amount of HOME funds awarded on a per-unit basis cannot exceed the pro rata or fair share of the total project costs when compared to a similar unit in a rental activity.

39.6(8) An application for a home ownership assistance activity must indicate that recipients will require the beneficiaries of the applicant's home ownership assistance activity to use a principal mortgage loan product that meets the following criteria:

a. With the exception of Habitat for Humanity principal mortgage loan products, the principal mortgage loan must be the only repayable loan in all individual home ownership assistance projects.

b. The HOME assistance must be recorded in second lien position to the principal mortgage loan, if one exists. Recipients of HOME home ownership assistance must maintain their assistance security agreements in the above-stated recording position throughout the applicable period of affordability and will not be allowed to subordinate the required recording position to any other form of assistance, such as home equity loans. A home buyer search is required, and any collection/unpaid obligation that would become a judgment or any judgments must be paid in full prior to closing.

c. Any mortgage lending entity's principal mortgage loan products may be used provided they meet all of the following minimum requirements:

(1) The loan must be a fully amortizing, fixed-rate loan with rate not to exceed Fannie Mae 90-day yield + 0.125% or VA-published interest rate at par;

(2) Loan terms must include an 80 percent or higher loan-to-value ratio;

(3) No less than a 15-year, fully amortized, fixed-rate mortgage shall be used; and

(4) No adjustable rate mortgages or balloon payment types of mortgages will be allowed.

d. Recipients are encouraged but not required to have the beneficiaries of their home ownership assistance activity utilize a principal mortgage loan product offered by one of the following: Iowa finance authority, USDA Rural Development, Federal Home Loan Bank, HUD (including FHA and VA), Habitat for Humanity, Fannie Mae, or Freddie Mac.

39.6(9) An application for a home ownership assistance activity must stipulate that home ownership assistance is for first-time home buyers only and that the assisted unit will remain as the assisted home buyer's principal residence throughout the required period of affordability, which must be verified annually by the subrecipient. If the assisted home buyer fails to maintain the home as the principal residence during the affordability period, then all HOME funds associated with that address must be repaid to IFA.

39.6(10) An application for a home ownership assistance activity must stipulate that all assisted units will be insured for at least the full value of the assisted unit, which must be verified annually by the subrecipient.

[**ARC 8963B**, IAB 7/28/10, effective 7/8/10; **ARC 9284B**, IAB 12/15/10, effective 1/19/11; **ARC 9764B**, IAB 10/5/11, effective 11/9/11]

265—39.7(16) Application review criteria.

39.7(1) IFA shall evaluate applications and make funding decisions based on general activity criteria, need, impact, feasibility, and activity administration based upon the specific type of activity to be undertaken. The activity criteria shall be a part of the application. Training will be offered prior to the application deadline to provide information and technical assistance to potential applicants.

39.7(2) A request for proposals shall be published by IFA when funds are available to award. The request for proposals shall specify the general criteria, need, impact and feasibility criteria, and the administrative criteria based on the activity proposed. Notice of the availability of funding will be placed on IFA's Web site at www.iowafinanceauthority.gov.

39.7(3) Special consideration will be given to applications where 100 percent of the HOME-funded rental units are fully accessible (not adaptable).

[**ARC 9284B**, IAB 12/15/10, effective 1/19/11]

265—39.8(16) Allocation of funds.

39.8(1) IFA may retain a portion of the amount up to 10 percent of the state's annual HOME allocation from HUD for administrative costs associated with program implementation and operation.

39.8(2) Not less than 15 percent of the state's annual HOME allocation shall be reserved for eligible housing activities developed, sponsored or owned by CHDOs.

39.8(3) IFA reserves the right to set aside a portion of the state's annual HOME allocation for rental housing activities jointly funded with HOME and low-income housing tax credits and for the Rural Development Section 515 Preservation Demonstration Program.

39.8(4) Not more than 5 percent of the state's annual HOME allocation may be reserved for CHDO operating expenses.

39.8(5) IFA reserves the right to limit the amount of funds that shall be awarded for any single activity type.

39.8(6) Awards shall be limited to no more than $600,000 for all single-family activities assisting home buyers. Awards shall be limited to no more than $1,000,000 for all multifamily rental activities.

39.8(7) Single-family per unit subsidies.

a. The maximum per unit subsidy for all single-family activities involving rehabilitation is $37,500. The $37,500 per unit limit includes all applicable costs including, but not limited to, the hard costs of rehabilitation or the acquisition subsidy or both; home ownership assistance activities; technical services costs, including lead hazard reduction carrying costs; lead hazard reduction costs; and temporary relocation. All rehabilitation hard costs funded with HOME funds are limited to $24,999. All applicable technical services costs, including any lead hazard reduction carrying costs, are limited to $4,500 per unit.

b. Assistance for single-family activities providing acquisition assistance for newly constructed housing (mortgage buy-down, downpayment or closing costs assistance or both, or combinations thereof) is limited to $35,000 per unit, inclusive of all costs, including technical services costs.

c. Assistance for single-family activities providing development subsidies for newly constructed housing is limited to $30,000 per unit. Development subsidies shall only be provided in addition to direct subsidies within home buyer assistance activities. When a development subsidy is used in combination with home buyer assistance activities, assistance is limited to $35,000 per unit, inclusive of all costs.

39.8(8) Multifamily per unit subsidies. The maximum per unit HOME funds subsidy for all multifamily activities is $70,000 per unit including both newly constructed units and the rehabilitation of existing multifamily units, including conversion activities. The $70,000 per unit multifamily limit includes all applicable costs including, but not limited to, hard costs of construction or rehabilitation; architectural design or technical services costs; lead hazard reduction or abatement costs; lead hazard reduction or abatement carrying costs; and temporary relocation.

39.8(9) Subrecipients shall identify general administrative costs in the HOME funds application. IFA reserves the right to negotiate the amount of funds provided for general administration, but in no case shall the amount for general administration exceed 10 percent of a total HOME funds award. Only local government and nonprofit recipients are eligible for general administrative funds. Subrecipients must certify that all general administrative costs reimbursed by HOME funds are separate from and not reimbursed by HOME funds as technical services costs.

39.8(10) IFA reserves the right to negotiate the amount and terms of a HOME funds award.

39.8(11) IFA reserves the right to make award decisions such that the state maintains the required level of local match to HOME funds.

[**ARC 8963B**, IAB 7/28/10, effective 7/8/10; **ARC 9284B**, IAB 12/15/10, effective 1/19/11; **ARC 9764B**, IAB 10/5/11, effective 11/9/11]

265—39.9(16) Administration of awards. Applicants selected to receive HOME funds awards shall be notified by letter from the IFA executive director or IFA affordable rental production division director.

39.9(1) *Preaudit survey.* Rescinded IAB 10/5/11, effective 11/9/11.

39.9(2) *Contract.* A contract shall be executed between the recipient and IFA. These rules, the approved application, the IFA HOME Program Guide for the specified activity and all applicable federal and state laws and regulations shall be part of the contract.

a. The recipient shall execute and return the contract to IFA within 45 days of transmittal of the final contract from IFA. Failure to do so may be cause for IFA to terminate the award.

b. Certain activities may require that permits or clearances be obtained from other state or local agencies before the activity may proceed. Contracts may be conditioned upon the timely completion of these requirements.

c. Awards shall be conditioned upon commitment of other sources of funds necessary to complete the housing activity.

d. Rescinded IAB 12/15/10, effective 1/19/11.

e. Release of funds shall be conditioned upon IFA's receipt and approval of documentation of environmental clearance.

39.9(3) *Local administrative and technical services contracts.*

a. Subrecipients awarded funds to perform the general administrative functions for home ownership assistance and tenant-based rental assistance activities shall enter into a contract for services with IFA.

b. Recipients awarded funds for activities requiring technical services (e.g., inspections, work write-ups, cost estimates, construction supervision, lead hazard reduction need determination and oversight, lead hazard reduction carrying costs, and temporary relocation coordination) that employ a third-party entity to perform all or part of the technical services shall enter into a contractual agreement for the technical services to be performed. The procurement must follow 24 CFR Part 84 and 24 CFR Part 85, when necessitated by those regulations.

39.9(4) *Requests for funds.* Recipients shall submit requests for funds in the manner and on forms prescribed by IFA. Individual requests for funds shall be made in whole dollar amounts equal to or greater than $500 per request, except for the final draw of funds. Adequate and itemized documentation supporting the amount of funds requested must be provided and approved by IFA prior to release of funds. IFA shall retain up to 10 percent of the HOME funds for development subsidies from payment to the recipient until 30 days after the recipient satisfactorily completes the work and full occupancy of the HOME-assisted units is attained. At IFA's discretion, up to 5 percent of the HOME funds for home buyer and tenant-based rental assistance activities may be retained from payment to the subrecipient for program or administrative costs until the final closeout documents are submitted to and approved by IFA.

39.9(5) *Record keeping and retention.*

a. HOME-funded projects. For HOME-funded projects, 24 CFR 92.508 provides the record retention requirements. All records pertaining to each fiscal year of HOME funds must be retained for the most recent five-year period, except as provided in the following:

(1) For rental housing projects, records may be retained for five years after the project completion date, except that records of individual tenant income verifications, project rents and project inspections must be retained for the most recent five-year period, until five years after the affordability period terminates;

(2) For home ownership housing projects, records may be retained for five years after the project completion date, except for documents imposing recapture/resale restrictions which must be retained for five years after the affordability period terminates;

(3) For tenant-based rental assistance projects, records must be retained for five years after the period of rental assistance terminates;

(4) Written agreements must be retained for five years after the agreement terminates;

(5) For records covering displacements and acquisitions, see 24 CFR 92.508;

(6) For records relating to litigation, see 24 CFR 92.508.

b. Representatives of IFA, HUD, the Inspector General, the General Accounting Office and the state auditor's office shall have access to all records belonging to or in use by recipients and subrecipients pertaining to a HOME funds award; to the total project receipts and expenditures related to new construction, acquisition, or rehabilitation; and to any records maintained by third-party administrators for general administration or technical services for the HOME-funded project. IFA reserves the right to demand any and all additional records and documents that may relate to the HOME award.

39.9(6) *Performance reports and reviews.* Recipients shall submit performance reports to IFA in the manner and on forms prescribed by IFA. Reports shall assess the use of funds and progress of activities. IFA may perform reviews or field inspections necessary to ensure recipient performance.

39.9(7) *Amendments to contracts.* Any substantive change to a contract shall be considered an amendment. Changes include time extensions, budget revisions and significant alterations of the funded activities affecting the scope, location, objectives or scale of the approved activity. Amendments shall be requested in writing by the CEO of the recipient and are not considered valid until approved in writing by IFA following the procedure specified in the contract between the recipient and IFA.

39.9(8) *Work completion closeout.* Upon the contract expiration date or work completion date, as applicable, and IFA's receipt of final draw and completion documentation, IFA shall initiate closeout procedures in IDIS. Recipients shall comply with applicable audit requirements, performance reports and Section 3 requirements and provide other required documents described in the HOME funds application, the contract, the IFA HOME Program Guide, and any other IFA HOME partnership program policies and procedures.

39.9(9) *Compliance with federal, state and local laws and regulations.* Recipients shall comply with these rules, with any provisions of the Iowa Code governing activities performed under this program and with applicable federal, state and local regulations.

39.9(10) *Remedies for noncompliance.* At any time, IFA may, for cause, find that a recipient is not in compliance with the requirements of this program. At IFA's discretion, remedies for noncompliance may include penalties up to and including the return of program funds to IFA. Reasons for a finding of noncompliance include the recipient's use of funds for activities not described in the contract, the recipient's failure to complete funded activities in a timely manner, the recipient's failure to comply with applicable state or local rules or regulations or the lack of a continuing capacity of the recipient to carry out the approved activities in a timely manner.

39.9(11) *Appeals process for findings of noncompliance.* Appeals will be entertained in instances where it is alleged that IFA staff participated in a decision which was unreasonable, arbitrary, or capricious or otherwise beyond the authority delegated to IFA. Appeals should be addressed to the director of the affordable rental production division. Appeals shall be in writing and submitted to IFA within 15 days of receipt of the finding of noncompliance. The appeal shall include reasons why the decision should be reconsidered. IFA's executive director will make the final decision on all appeals.

[**ARC 8963B**, IAB 7/28/10, effective 7/8/10; **ARC 9284B**, IAB 12/15/10, effective 1/19/11; **ARC 9764B**, IAB 10/5/11, effective 11/9/11]

These rules are intended to implement Iowa Code sections 16.5(1)*"f"* and 16.5(1)*"m"* and the Cranston-Gonzalez National Affordable Housing Act of 1990.

[Filed Emergency ARC 8963B, IAB 7/28/10, effective 7/8/10]
[Filed ARC 9284B (Notice ARC 9159B, IAB 10/20/10), IAB 12/15/10, effective 1/19/11]
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[Filed ARC 9764B (Notice ARC 9644B, IAB 7/27/11), IAB 10/5/11, effective 11/9/11]
[Filed Emergency ARC 0003C, IAB 2/8/12, effective 1/20/12]

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]

Rules transferred from agency number [190] to [121] to conform with the reorganization numbering scheme in general, IAC Supp. 9/9/87.
Prior to 3/30/94, Campaign Finance Disclosure Commission [121]

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[Prior to 3/30/94, Campaign Finance Disclosure Commission[121] Ch 10]
[Prior to 8/20/03, see 351—Ch 10]

351—2.1(22,68A,68B) Definitions. As used in this chapter:

"Confidential record" means a record that is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records may include information discovered as the result of an investigation until such time as the final action of the board is ordered. Confidential records also include matters in litigation by the board and information conveyed as a result of the attorney/client relationship. Confidential records also include records or information contained in records that the board is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7, or other provision of law, but that may be disclosed upon order of a court, by the lawful custodian of the record, or by another person duly authorized to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

"Custodian" means the executive director of the Iowa ethics and campaign disclosure board, who is the person lawfully delegated authority by the policy-setting board to act for the agency in implementing Iowa Code chapter 22.

"Open record" means a record other than a confidential record.

"Personally identifiable information" means information about or pertaining to an individual in a record that identifies the individual and that is contained in a record system.

"Record" means the whole or a part of a "public record" as defined in Iowa Code section 22.1 that is owned by or is in the physical possession of the board.

"Record system" means any group of records under the control of the board from which a record may be retrieved by a personal identifier such as the name of an individual, number, symbol, or other unique retriever assigned to an individual.

351—2.2(22,68A,68B) Statement of policy. The purpose of this chapter is to facilitate broad public access to open records. It also seeks to facilitate sound board determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. The board is committed to the policies set forth in Iowa Code chapter 22, and board staff shall cooperate with members of the public in implementing the provisions of that chapter.

351—2.3(22,68A,68B) Requests for access to records.

2.3(1) *Location of record.* A request for access to a record shall be directed to the Iowa Ethics and Campaign Disclosure Board, 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. If the requested record is not on file in the board office, the custodian will arrange for it to be retrieved from state archives and made available in the board office.

2.3(2) *Office hours.* Records shall be made available from 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays, and legal holidays. Records made available via the board's Web site at www.iowa.gov/ethics are available at all hours and on all days.

2.3(3) *Request for access.* Requests for access to records may be made in writing, in person, or by telephone. Requests shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

2.3(4) *Granting access to records.* The custodian is authorized to grant or deny access to the record according to the provisions of Iowa Code chapter 22 and this chapter. The decision to grant or deny access may be delegated to one or more designated employees. Access to an open record shall be granted immediately upon request. If the size or nature of the request requires time for compliance, the board shall comply with the request as soon as possible. However, access to such a record may be delayed for

one of the purposes authorized by Iowa Code chapter 22. The board shall promptly inform the requester of the reason for the delay.

2.3(5) *Security of record.* No person shall, without permission, search or remove any record from board files. Examination and copying of records shall be done under the supervision of board staff. Records shall be protected from damage and disorganization.

2.3(6) *Copying.* A reasonable number of copies may be made in the board office unless printed copies are available. If copying equipment is not available in the office where a record is kept, the board shall permit its examination in that office and shall arrange to have copies promptly made elsewhere. Records made available on the board's Web site may be copied without restriction.

2.3(7) *Fees.*

a. Copying costs. Price schedules for regularly published records and for copies of records not regularly published shall be posted by the board. Copies may be made by or for members of the public at cost as determined and posted by the custodian of the record. The cost of postage and of other services provided in connection with the request may be charged as appropriate.

b. Search and supervisory fee. An hourly fee may be charged for actual board expenses in searching for, and supervising the examination and copying of, requested records. The fee shall be based upon the pay scale of the employee involved and other actual costs incurred. No fee shall be charged if the records are not made available for inspection, or if the time required does not exceed one-half hour in duration, or if the time required for the search was the result of a board error or a record-keeping problem. The board shall post the hourly fees to be charged in routine cases for search and supervision of records. The board shall give advance notice to the requester if it will be necessary to use an employee with a higher hourly wage in order to find or supervise the particular records in question, and shall indicate the amount of that higher hourly wage to the requester.

c. Advance deposits.

(1) The board may require a requester to make an advance deposit of the estimated fee.

(2) When a requester has previously failed to pay a fee charged under this subrule, the board may require advance payment of the full amount of any estimated fee before the board processes a new or pending request for access to records from that requester, as well as payment in full of the amount previously owed.

351—2.4(22,68A,68B) Procedures for access to confidential records. The following procedures for access to confidential records are in addition to those specified for all records in rule 351—2.3(22,68A,68B).

2.4(1) *Proof of identity.* A person requesting access to a confidential record shall be required to provide proof of identity.

2.4(2) *Requests.* A request to review a confidential record shall be in writing. A person requesting access to a confidential record may be required to sign a certified statement or affidavit enumerating the specific grounds justifying access to the confidential record and to provide any proof necessary to establish relevant facts. Such request may be referred to the full board for consideration.

2.4(3) *Request denied.* When the custodian of a confidential record or the board denies a request for access to a confidential record, in whole or in part, the requester shall be notified in writing. The denial shall be signed by the custodian of the confidential record and shall include:

a. The name and title or position of the person or persons responsible for the denial and a brief citation to the statute or other provision of law that prohibits disclosure of the record;

b. A brief citation to the statute vesting discretion in the custodian to deny disclosure of the record; and

c. A brief statement of the grounds for the denial to this requester.

351—2.5(22,68A,68B) Request for treatment of a record as a confidential record.

2.5(1) *Who may file request.* Any person who would be aggrieved or adversely affected by disclosure of all or a part of a record to members of the public may file a request, as provided in this rule, for its treatment as a confidential record. Failure of a person to request confidential record treatment for all

or part of a record, such as information obtained in the course of a board investigation or to achieve voluntary compliance with Iowa Code chapter 68A or 68B, does not preclude the board from treating it as a confidential record. The information may become a public record once the matter is resolved or dismissed.

2.5(2) *Form of request.* A request for the treatment of a record as a confidential record shall be in writing and shall be filed with the custodian of the record. The request shall include the specific grounds justifying confidential record treatment for all or part of the record; the specific provision of law that authorizes such confidential record treatment; and the name, address, and telephone number of the person authorized to respond to any board action concerning the request. A person filing such a request shall attach a copy of the record in question. The material to which the request applies shall be physically separated from any materials to which the request does not apply. The request shall be attached to the materials to which it applies. Each page of the material to which the request applies shall be clearly marked confidential. If the original record is being submitted to the board by the person requesting confidentiality at the same time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are a confidential record. A request for treatment of all or portions of a record as a confidential record for a limited time period shall also specify the precise period of time for which such confidential record treatment is requested.

2.5(3) *Failure to request confidentiality.* If a person who has submitted business information to the board does not request confidential record treatment for all or part of that information, the custodian of records containing that information may assume that the person who submitted the information has no objection to its disclosure.

2.5(4) *Time.* A board decision with respect to the disclosure of all or parts of a record may be made when a request for its treatment as a confidential record is filed or when the board receives a request for access to the record.

2.5(5) *Effect of granted request.* If a request for confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the board decision will be placed in the public file in lieu of the original record.

2.5(6) *Effect of denied request.* If a request for confidential record treatment is denied, the board shall advise the requester in writing on the grounds the request was denied and treat the record as a confidential record for 30 days to allow the person requesting such treatment for the record an opportunity to seek injunctive relief. However, if the board determines that a 30-day delay is not in the public interest and furnishes the requester with a written copy of that determination, including the appropriate grounds, the record will be treated as a confidential record for at least three working days unless prior release of the record is necessary to avoid imminent peril to the public health, safety, or welfare. The board may extend the period of confidential record treatment of such a record beyond 30 days only if a court directs the board to treat the record as a confidential record or to the extent permitted by Iowa Code chapter 22 or with the consent of the person requesting access.

[Editorial change: IAC Supplement 4/8/09]

351—2.6(22,68A,68B) Procedure by which a subject may have additions, dissents or objections entered into the record. Except as otherwise provided by law, the subject shall have the right to have a written statement of additions, dissents or objections entered into the record. However, any additions, dissents or objections entered into the record shall not be considered evidence in a contested case proceeding. The subject shall send the statement to the Executive Director, Iowa Ethics and Campaign Disclosure Board, 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. The statement shall be dated and signed by the subject and shall include the subject's current address and telephone number.

351—2.7(22,68A,68B) Consent to disclosure by the subject of a confidential record. The subject of a confidential record may consent to board disclosure to a third party of that portion of the record concerning the subject. The consent must be in writing and must identify the particular record that may be disclosed, the particular person or class of persons to whom the record may be disclosed, and, where

applicable, the time period during which the record may be disclosed. The subject and, where applicable, the person to whom the record is to be disclosed must provide proof of identity.

351—2.8(22,68A,68B) Notice to suppliers of information. When the board requests persons to supply information about themselves, the board shall notify those persons of the use that will be made of the information, which persons outside the board might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information. Notice may be given in this chapter, on the written form used to collect the information, in a separate fact sheet or letter, in brochures, in formal agreements or contracts, in handbooks or manuals, orally, or by other appropriate means.

351—2.9(22,68A,68B) Disclosure without the consent of the subject.

2.9(1) *Open record.* An open record is routinely disclosed without the consent of the subject.

2.9(2) *Partial open record.* If the board is prohibited from disclosing part of a document from inspection, that part will not be disclosed and the remainder will be made available for inspection.

2.9(3) *Disclosure of confidential record.* To the extent allowed by law, disclosure of a confidential record may occur without the consent of the subject. Following are instances when disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 351—2.10(22,68A,68B) or in the notice for a particular record system.

b. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of the government agency or instrumentality has submitted a written request to the board specifying the record desired and the law enforcement activity for which the record is sought.

c. To the legislative services agency.

d. In response to a court order or subpoena.

e. To a recipient who has provided the board with advance written assurance that the record will be used solely as a statistical research or reporting record, provided that the record is transferred in a form that does not identify the subject.

f. To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last-known address of the subject.

g. Disclosures in the course of employee disciplinary proceedings.

351—2.10(22,68A,68B) Routine use.

2.10(1) *Defined.* "Routine use" means the disclosure of a record without the consent of the subject or subjects for a purpose that is compatible with the purpose for which the record was collected. "Routine use" includes disclosures required to be made by statute other than Iowa Code chapter 22.

2.10(2) *Examples of routine uses.* To the extent allowed by law, the following are considered routine uses of all board records:

a. Disclosure to officers, employees, and agents of the board who have a need for the record in the performance of their duties. The custodian of the record may, upon request of any officer or employee, or on the initiative of the custodian, determine what constitutes legitimate need to use confidential records.

b. Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.

c. Transfers of information within the board, to other state and federal agencies, or to local units of government as appropriate to administer the program for which the information is collected.

d. Information released to staff of federal and state entities for audit purposes or for purposes of determining whether the board is operating a program lawfully.

e. Any disclosure specifically authorized by the statute under which the record was collected or maintained, including disclosure to the general public of information contained in reports required to be filed by Iowa Code chapter 68A or 68B.

f. The following records are routinely disseminated to members of the public:

(1) Reports and statements filed by campaign committees as authorized by Iowa Code chapter 68A.

(2) Reports and statements filed by executive branch lobbyists as authorized by Iowa Code chapter 68B.

(3) Personal financial disclosure forms filed by designated persons in the executive branch as authorized by Iowa Code section 68B.35.

[Editorial change: IAC Supplement 4/8/09]

351—2.11(22,68A,68B) Consensual disclosure of confidential records.

2.11(1) *Consent to disclosure by a subject individual.* To the extent permitted by law, the subject may consent in writing to board disclosure of confidential records as provided in rule 351—2.7(22,68A,68B).

2.11(2) *Complaints to public officials.* A letter from a subject of a confidential record to a public official that seeks the official's intervention on behalf of the subject in a matter that involves the board may, to the extent permitted by law, be treated as an authorization to release sufficient information about the subject to the official to resolve the matter.

351—2.12(22,68A,68B) Release to subject.

2.12(1) *Filing of request.* The subject of a confidential record may file a written request to review a confidential record about that person as provided in rule 351—2.6(22,68A,68B). However, the board need not release the following records to the public:

a. The identity of a person providing information to the board need not be disclosed directly or indirectly to the subject when the information is authorized to be held confidential pursuant to Iowa Code section 22.7(18) or other provision of law.

b. Records need not be disclosed to the subject when they are the work product of an attorney or are otherwise privileged.

c. Peace officers' investigative reports may be withheld from the subject except as required by Iowa Code section 22.7(5).

d. As otherwise authorized by law.

2.12(2) *Multiple subjects.* When a record has multiple subjects with interest in the confidentiality of the record, the board may take reasonable steps to protect confidential information relating to more than one subject.

351—2.13(22,68A,68B) Availability of records.

2.13(1) *General.* Board records are open for public inspection and copying unless otherwise provided by rule or law.

2.13(2) *Confidential records.* The following records may be withheld from public inspection:

a. Sealed bids received prior to the time set for public opening of bids under Iowa Code section 72.3.

b. Tax records made available to the board under Iowa Code sections 422.72 and 422.20.

c. Records that are exempt from disclosure under Iowa Code section 22.7.

d. Agendas, minutes and tape recordings of closed meetings of a government body pursuant to Iowa Code subsection 21.5(4).

e. Records that constitute attorney work product, attorney-client communications, or that are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10, and 622.11. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, and the Code of Professional Responsibility.

f. Those portions of the board's staff manuals, instructions or other statements issued that set forth criteria or guidelines to be used by the board staff in auditing, in making inspections, in settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases,

such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when disclosure of these statements would:

(1) Enable law violators to avoid detection;

(2) Facilitate disregard of requirements imposed by law; or

(3) Give a clearly improper advantage to persons who are in an adverse position to the board.

g. Identifying details in final orders, decisions and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3(1)*"d."*

h. Any other records made confidential by law.

2.13(3) *Authority to release confidential records.* The board may have discretion to disclose some confidential records that are exempt from disclosure under Iowa Code section 22.7 or other law. Any person may request permission to inspect records withheld from inspection under a statute that authorizes limited or discretionary disclosure as provided in rule 351—2.4(22,68A,68B). If the board initially determines that it will release such records, the board may, where appropriate, notify interested parties and withhold the records from inspection as provided in subrule 2.4(3).

351—2.14(22,68A,68B) Personally identifiable information. This rule describes the nature and extent of personally identifiable information that is collected, maintained, and retrieved by the board by personal identifier in record systems as defined in rule 351—2.1(22,68A,68B). For each record system, this rule describes the legal authority for the collection of that information and the means of storage of information and indicates whether a data processing system matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system. The record systems maintained by the board are:

2.14(1) *Personnel files.* The board maintains files containing information about employees, families and dependents, and applicants for positions with the board. The files include payroll records, biographical information, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship. Some of this information is confidential under Iowa Code section 22.7(11).

2.14(2) *Campaign finance organization statements.* These records include the name and address of the campaign committee and the name and address of the committee officers. The name of the committee may contain a personal identifier. This information is collected pursuant to Iowa Code section 68A.201 or may be voluntarily submitted and is stored on paper and in an automated data processing system. The information stored in the data processing system does not match, collate or permit comparison with other data processing systems. The information contained in statements of organization is public information.
[Editorial change: IAC Supplement 4/8/09]

351—2.15(22,68A,68B) Other groups of records. This rule describes groups of records maintained by the board other than record systems as defined in rule 351—2.1(22,68A,68B). These records are routinely available to the public. However, the board's files of these records may contain confidential information pursuant to rule 351—2.13(22,68A,68B). The records listed may contain information about individuals. Unless otherwise stated, the authority for the board to maintain the record is provided by Iowa Code chapters 22, 68A and 68B.

2.15(1) *Rule making.* Public documents generated during the promulgation of board rules, including notices and public comments, are available for public inspection. This information is collected pursuant to Iowa Code section 17A.4. This information is not stored in an automated data processing system.

2.15(2) *Board records.* Agendas, minutes, and materials presented to the ethics and campaign disclosure board are available from the custodian, except those records concerning closed sessions that are exempt from disclosure under Iowa Code section 21.5 or that are otherwise confidential by law. Board records may contain information about persons who participate in meetings. This information is collected pursuant to Iowa Code section 21.3. These records are not stored in an automated data processing system and may not be retrieved by a personal identifier.

2.15(3) *Publications.* The board receives a number of books, periodicals, newsletters, and government documents. These materials would generally be open to the public but may be protected by copyright law. Most publications of general interest are available in the state library or law library. These records are not stored in an automated data processing system and may not be retrieved by a personal identifier.

2.15(4) *Office publications.* The board publishes instructional manuals, forms, form letters, calendars, and brochures. These publications are routinely made available to the public. This information is not stored in an automated data processing system.

2.15(5) *Administrative records.* These records include documents concerning budget, property inventory, purchasing, yearly reports, office policies for employees, time sheets, office correspondence, and printing and supply requisitions. Some of this information is in the state of Iowa automated data processing system.

2.15(6) *Decisions, orders, and opinions.* All final decisions, orders, and opinions are available for public inspection in accordance with Iowa Code section 17A.3. These records may contain personally identifiable information regarding individuals who are the subjects or requesters of the order, decision, or opinion. This information is collected pursuant to Iowa Code chapters 17A and 68B. This information is not stored in an automated data processing system.

2.15(7) *Policy manuals.* The board employees' manual, containing the policies and procedures for programs administered by the board, is available from the custodian except as noted in rule 351—2.14(22,68A,68B).

2.15(8) *Campaign finance disclosure reports.* These records contain information about campaign committees that include itemization of the source of contributions, a list of expenditures, itemization of fundraising events, debts incurred, donors of goods or services, loan transactions, and details of contracts with consultants. These records may include an individual's name and address. These records are required by Iowa Code section 68A.402 and may be voluntarily submitted. These records are available by paper and are accessible via the board's Web site at www.iowa.gov/ethics.

2.15(9) *Federal repository.* The board serves as the Iowa repository for public viewing of a variety of disclosure reports required to be filed under the jurisdiction of the Federal Election Commission. These records are accessible via the board's Web site at www.iowa.gov/ethics through a computer modem connected with the Federal Election Commission's database. The computer records are for viewing, and reports may be printed. The terminal does not permit these records to be changed or deleted. Reports are accessed by the name of the reporting committee. Information in this database does not match, collate, or permit comparison with other data processing systems.

2.15(10) *Executive branch lobbying reports.* The general assembly serves as the repository for public viewing of executive branch lobbyist registration statements and executive branch lobbyist client reports. These reports are accessible via the board's Web site at www.iowa.gov/ethics. The information disclosed on these reports is required by 2011 Iowa Code Supplement sections 68B.36 and 68B.38. This information does not match, collate, or permit comparison with other data processing systems.

2.15(11) *Personal financial disclosure.* The board serves as the repository for the filing of personal financial disclosure forms (Form PFD) for designated positions in the executive branch. These reports are available by paper and are also accessible via the board's Web site at www.iowa.gov/ethics. The information disclosed on these forms is required by Iowa Code section 68B.35. This information does not match, collate, or permit comparison with other data processing systems.

[Editorial change: IAC Supplement 4/8/09; **ARC 9986B**, IAB 2/8/12, effective 3/14/12]

351—2.16(22,68A,68B) Data processing systems. None of the data processing systems used by the board compare personally identifiable information in one record system with personally identifiable information in another record system.

351—2.17(22,68A,68B) Limitation of applicability. This chapter does not:

2.17(1) Require the board to index or retrieve records that contain information about a person by that person's name or other personal identifier.

2.17(2) Make available to the general public a record that would otherwise not be available to the general public under Iowa Code chapter 22.

2.17(3) Govern the maintenance or disclosure of, notification of or access to, a record in the possession of the board that is governed by the rules of another agency.

2.17(4) Apply to grantees, including local governments or subdivisions thereof, administering state-funded programs, unless otherwise provided by law or agreement.

2.17(5) Make available records compiled by the board in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any subject individual or party to such litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the board.

351—2.18(68B) Use of information prohibited. Pursuant to Iowa Code section 68B.32A(7), the information obtained from statements or reports filed with the board under Iowa Code chapter 68A, Iowa Code chapter 68B, Iowa Code section 8.7, or rules adopted by the board shall not be copied or otherwise used for any commercial purpose. For purposes of this rule, "commercial purpose" shall include solicitations by a business or charitable organization.

2.18(1) *Exceptions.* The following uses of information for solicitations are permissible:

a. Information used in newspapers, magazines, books, or other similar communications, so long as the principal purpose of such communications is for providing information to the public and not for other commercial purpose.

b. Soliciting political campaign contributions.

2.18(2) *Sanctions.* Any person violating this rule shall be subject to the board's disciplinary process set out in Iowa Code chapter 68B and the board's rules.

[Editorial change: IAC Supplement 4/8/09]

These rules are intended to implement Iowa Code chapters 22, 68A and 68B.

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CHAPTER 8
EXECUTIVE BRANCH LOBBYING
[Prior to 11/26/03, see 351—Ch 13]

351—8.1(68B) Executive branch lobbying defined. "Executive branch lobbying" means acting directly to encourage the passage, defeat, approval, veto, or modification of legislation, a rule, or an executive order by a state agency or any statewide elected official. For purposes of this chapter, "state agency" does not include the legislative branch of state government.

This rule is intended to implement Iowa Code section 68B.2(13).

351—8.2(68B) Executive branch lobbyist defined. "Executive branch lobbyist" means an individual who by acting directly does at least one of the following:

1. Receives compensation for engaging in executive branch lobbying.
2. Is a designated representative of an organization that has as one of its purposes engaging in executive branch lobbying.
3. Represents the position of a federal, state, or local agency in which the person serves or is employed as the representative designated to engage in executive branch lobbying.
4. Makes expenditures of more than $1,000 in a calendar year to communicate in person for the purpose of engaging in executive branch lobbying.

This rule is intended to implement Iowa Code section 68B.2(13).

351—8.3(68B) Individuals not considered executive branch lobbyists. The following individuals are not considered to be executive branch lobbyists:

1. Officials and employees of a political party that is organized in the state of Iowa and that meets the requirements of Iowa Code section 43.2, when the officials and employees represent the political party in an official capacity.
2. Representatives of the news media only when engaged in the reporting and dissemination of news and editorials.
3. All federal, state, and local elected officials, while performing the duties and responsibilities of office.
4. Individuals whose activities are limited to appearances to give testimony or provide information or assistance at public hearings of state agencies or who are giving testimony or providing information or assistance at the request of public officials or employees.
5. Members of the staff of the United States Congress or the Iowa general assembly.
6. Agency officials and employees while they are engaged in activities within the agency in which they serve or are employed or with another agency within which an official's or employee's agency is involved in a collaborative project.
7. An individual who is a member, director, trustee, officer, or committee member of a business, trade, labor, farm, professional, religious, education, or charitable association, foundation, or organization and who is not paid compensation or is not specifically designated as an executive branch lobbyist.
8. Individuals whose activities are limited to submitting data, views, or arguments in writing, or requesting an opportunity to make an oral presentation under Iowa Code section 17A.4(1).
9. Individuals whose activities are limited to monitoring or following the progress of legislation, a rule, or an executive order, but who do not engage in executive branch lobbying.
10. Individuals who represent a client in responding to a request for proposal or otherwise receiving a contract or grant from a state agency.
11. Individuals who represent a client involved in a legal dispute with the state, including a contested case proceeding.
12. Individuals advocating for or against the appointment of a particular individual to a board or commission of the state.

Individuals who are uncertain as to whether or not they are considered executive branch lobbyists should contact the board for guidance prior to engaging in any executive branch lobbying.

This rule is intended to implement Iowa Code section 68B.2(13).

351—8.4(68B) Executive branch lobbyist client defined. "Executive branch lobbyist client" means a private person or a federal, state, or local governmental entity that pays compensation to or designates an individual to be a lobbyist before the executive branch.

This rule is intended to implement Iowa Code section 68B.2(6).

351—8.5(68B) Lobbyist compensation defined; contingency fee lobbying prohibited.

8.5(1) *Lobbyist compensation defined.* "Lobbyist compensation" means any money, thing of value, or financial benefit conferred in return for engaging in executive branch lobbying.

8.5(2) *Contingency fee lobbying prohibited.* No person shall offer, nor shall any person accept, compensation contingent upon the outcome of executive branch lobbying services rendered or to be rendered. Complaints or information alleging a violation of this subrule shall be filed with the board and governed by Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.2(7).

351—8.6(68B) Executive branch lobbying expenditures. Rescinded IAB 6/2/10, effective 7/7/10.

351—8.7(68B) Lobbyist registration required.

8.7(1) *Time of filing.* Any individual engaging in executive branch lobbying activity shall register by electronically filing an executive branch lobbyist registration statement with the chief clerk of the house of representatives or the secretary of the senate on or before the day the lobbying activity begins. Registration expires at the end of the calendar year. Beginning December 1 of each year, a person may preregister to lobby for the following calender year.

8.7(2) *Place of filing.* Executive branch lobbyist registration statements shall be electronically filed with the chief clerk of the house of representatives or the secretary of the senate through the general assembly's Web site at http://www.legis.iowa.gov/Lobbyist/reports.aspx.

8.7(3) *Amendment to registration.* Any change or addition to the information in an executive branch lobbyist's registration statement shall be filed with the chief clerk of the house of representatives or the secretary of the senate within ten days after the change or addition is made known to the lobbyist. The lobbyist may file changes or additions by electronically filing an amended registration statement.

8.7(4) *Failure to timely file registration.* An individual who fails to file an executive branch lobbyist registration statement before engaging in executive branch lobbying activities in violation of 2011 Iowa Code Supplement section 68B.36 may be subject to sanctions by the board as permitted under Iowa Code chapter 68B or rule 351—9.4(68B).

This rule is intended to implement 2011 Iowa Code Supplement section 68B.36.

[**ARC 8483B**, IAB 1/13/10, effective 1/25/10; **ARC 8805B**, IAB 6/2/10, effective 7/7/10; **ARC 9985B**, IAB 2/8/12, effective 3/14/12]

351—8.8(68B) Executive branch periodic lobbyist reports. Rescinded IAB 6/2/10, effective 7/7/10.

351—8.9(68B) Executive branch lobbyist client reporting.

8.9(1) *Place of filing.* Executive branch lobbyist client reports shall be electronically filed with the general assembly through the general assembly's Web site at http://www.legis.iowa.gov/Lobbyist/onlineFiling.aspx.

8.9(2) *Time of filing.* An executive branch lobbyist client report shall be filed on or before July 31 unless the due date is extended by the general assembly.

This rule is intended to implement 2011 Iowa Code Supplement section 68B.38.

[Editorial change: IAC Supplement 4/8/09; **ARC 8483B**, IAB 1/13/10, effective 1/25/10; **ARC 8805B**, IAB 6/2/10, effective 7/7/10; **ARC 9984B**, IAB 2/8/12, effective 3/14/12]

351—8.10(68B) Session function registrations and reports. Pursuant to Iowa Code section 68B.22(4)*"s"* as amended by 2010 Iowa Acts, House File 2109, section 1, a sponsor of a qualified

function is required to file with the general assembly and the board a registration notice prior to the function and a report within 28 days of the function. The board will deem filings with the general assembly as acceptable filings with the board. The board will establish links on its Web site to the general assembly's Web site where the registration notices and reports are posted. The failure of a sponsor to timely file either a registration notice or a report may subject the sponsor to sanctions by the board as permitted under Iowa Code chapter 68B and rule 351—9.4(68B) separate from any sanctions imposed by the general assembly.

This rule is intended to implement Iowa Code section 68B.22(4)*"s"* as amended by 2010 Iowa Acts, House File 2109, section 1, and Iowa Code section 68B.32A(5) as amended by 2010 Iowa Acts, Senate File 2067, section 4.
[**ARC 8805B**, IAB 6/2/10, effective 7/7/10]

351—8.11(68B) Penalties for delinquent reports.

8.11(1) *Late client report.* An executive branch lobbyist client who fails to file an executive branch lobbyist client report on or before the required due date shall be subject to an automatic civil penalty according to the following schedule:

Days Delinquent	Amount
1 to 14	$25
15 to 30	$50
31 and over	$100

8.11(2) *Additional penalty.* If an executive branch lobbyist client fails to file a required report or fails to file an accurate report, a contested case proceeding may be held to determine whether a violation has occurred. If, after a contested case proceeding, it is determined that a violation occurred, the board may impose any of the actions under Iowa Code section 68B.32D. Any action so imposed would be in addition to the automatically assessed penalty in this rule.

This rule is intended to implement Iowa Code section 68B.32A(5) as amended by 2010 Iowa Acts, Senate File 2067, section 4, and Iowa Code section 68B.32A(9).
[Editorial change: IAC Supplement 4/8/09; **ARC 8805B**, IAB 6/2/10, effective 7/7/10]

351—8.12(68B) Request for waiver of penalty. An executive branch lobbyist client that believes there are mitigating circumstances that prevented the timely filing of a report may make a written request to the board for waiver of the penalty. The board must receive the request for waiver within 30 days of the executive branch lobbyist client's being notified of the civil penalty assessment by filing a Petition for Waiver of Civil Penalty form. Waivers will be granted only for exceptional or very unusual circumstances. The board will review the request and issue a waiver or denial of the request. If a waiver is granted, the board will determine how much of the penalty is waived based on the circumstances. If a denial or partial waiver is issued, the person shall promptly pay the assessed penalty or request a contested case proceeding pursuant to rule 351—8.13(68B) to appeal the board's decision.

This rule is intended to implement Iowa Code section 68B.32A(5) as amended by 2010 Iowa Acts, Senate File 2067, section 4, and Iowa Code section 68B.32A(9).
[Editorial change: IAC Supplement 4/8/09; **ARC 7996B**, IAB 7/29/09, effective 9/2/09; **ARC 8805B**, IAB 6/2/10, effective 7/7/10]

351—8.13(68B) Contested case proceeding.

8.13(1) *Request.* If an executive branch lobbyist client accepts administrative resolution of a matter through the payment of an assessed civil penalty, the matter shall be closed. If the person chooses to contest the board's decision to deny a request or grant a partial waiver of an assessed civil penalty, the person shall make a written request for a contested case proceeding within 30 days of being notified of the board's decision.

8.13(2) *Procedure.* Upon timely receipt of a request for a contested case proceeding, the board shall provide for the issuance of a statement of charges and notice of hearing. The hearing shall be conducted

in accordance with the provisions of Iowa Code section 68B.32C and the board's rules. The burden shall be on the board's legal counsel to prove that a violation occurred.

8.13(3) *Failure to request a contested case proceeding.* The failure to request a contested case proceeding to appeal the board's decision on a waiver request is the failure to exhaust administrative remedies for purposes of seeking judicial review in accordance with Iowa Code chapter 17A and Iowa Code section 68B.33.

This rule is intended to implement Iowa Code section 68B.32A(5) as amended by 2010 Iowa Acts, Senate File 2067, section 4, and Iowa Code sections 68B.32A(9) and 68B.33.
[Editorial change: IAC Supplement 4/8/09; **ARC 8805B**, IAB 6/2/10, effective 7/7/10]

351—8.14(68B) Payment of penalty. An assessed civil penalty shall be paid by check or money order and shall be made payable to the State of Iowa General Fund and forwarded to: Iowa Ethics and Campaign Disclosure Board, 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319. The payment shall be deposited in the general fund of the state of Iowa.

This rule is intended to implement Iowa Code sections 68B.32A(5) and 68B.32A(9).
[Editorial change: IAC Supplement 4/8/09]

351—8.15(68A) Campaign contributions by lobbyists during the regular legislative session prohibited. Pursuant to Iowa Code section 68A.504, individuals who are registered in Iowa as either executive branch or legislative branch lobbyists are prohibited from contributing to, acting as an agent or intermediary for contributions to, or arranging for the making of monetary or in-kind contributions to the campaign of an elected state official, member of the general assembly, or candidate for state office on any day during the regular legislative session. This prohibition includes a contribution that is mailed during the legislative session but received by the candidate after the legislative session has adjourned.

8.15(1) *Application to governor.* The prohibition on contributions to the governor or a gubernatorial candidate during session extends for an additional 30 days following the adjournment of a regular legislative session allowed for the signing of bills.

8.15(2) *Exceptions.* The prohibition on contributions during the regular legislative session does not apply to any of the following:

a. Contributions to an elected state official, member of the general assembly, or other state official who has taken affirmative action to seek nomination or election to a federal elective office so long as the lobbyist's contribution is placed into the candidate's federal account.

b. Contributions to a candidate for state office who filed nomination papers for a special election called or held during the regular legislative session if the candidate receives the contribution at any time during the period commencing on the date on which at least two candidates have been nominated for the office and ending on the date on which the election is held. However, elected state officials are prohibited from soliciting lobbyists for contributions to another candidate for state office when a special election is held during the regular legislative session.

c. Contributions made during a special legislative session. In the case of the governor and a gubernatorial candidate, this exception also includes the 30 days following a special legislative session unless that time period falls within 30 days of adjournment of the regular legislative session.

d. Contributions from a lobbyist's personal funds that a lobbyist makes to the lobbyist's own campaign for public office.

8.15(3) *Complaints.* Complaints or information provided to the board alleging a violation of Iowa Code section 68A.504 involving either executive branch lobbyists or legislative branch lobbyists shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

8.15(4) *Date of session.* For purposes of Iowa Code section 68A.504 and this rule, a legislative session commences at 12 a.m. of the first day of the legislative session through 11:59:59 p.m. of the day that the legislative session adjourns sine die.

This rule is intended to implement Iowa Code section 68A.504.
[**ARC 7651B**, IAB 3/25/09, effective 4/29/09; Editorial change: IAC Supplement 4/8/09]

351—8.16(68B) Lobbyists prohibited from making loans. Pursuant to Iowa Code section 68B.24, an executive branch official, executive branch employee, or a candidate for statewide office shall not directly or indirectly seek or accept a loan from a person who is an executive branch lobbyist.

8.16(1) *Offer of loan prohibited.* An executive branch lobbyist shall not directly or indirectly offer or make a loan to an executive branch official, executive branch employee, or a candidate for statewide office.

8.16(2) *Exception.* The prohibitions in Iowa Code section 68B.24 do not apply to loans made in the ordinary course of business. "Ordinary course of business" means the loan is made by a person who is regularly engaged in a business that makes loans to members of the general public, and the finance charges and other terms of the loan are the same or substantially similar to the finance charges and loan terms that are available to members of the general public.

8.16(3) *Complaints.* Complaints or information provided to the board alleging a violation of Iowa Code section 68B.24 by an executive branch official, executive branch employee, candidate for statewide office, or an executive branch lobbyist shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.24.

351—8.17(68B) Ban on certain lobbying activities by government personnel. Executive branch officials and executive branch employees are prohibited by Iowa Code section 68B.5A from engaging in certain types of lobbying activities during the time in which these officials and employees serve or are employed by the state. In addition, Iowa Code section 68B.5A prohibits executive branch officials and executive branch employees from accepting, under certain situations, employment as lobbyists within two years of leaving state government.

8.17(1) *Lobbying restrictions—statewide elected officials and executive or administrative heads.*

a. A person who serves as a statewide elected official, the executive or administrative head of an agency, or the deputy executive or administrative head of an agency shall not act as a lobbyist during the time in which the person serves or is employed by the state unless the person is designated to represent the official position of the person's agency.

b. A person subject to this prohibition may not accept employment as a lobbyist for two years after leaving state government except as provided in subrule 8.17(4).

8.17(2) *Lobbying restrictions—employees of statewide elected officials and other department or agency employees.*

a. The head of a major subunit of a department or independent state agency whose position involves substantial exercise of administrative discretion or the expenditure of public funds or a full-time employee of an office of a statewide elected official whose position involves substantial exercise of administrative discretion or the expenditure of public funds shall not act as a lobbyist during the time in which the person is employed by the state before the agency that the person is employed by or before state agencies, officials, or employees with whom the person has substantial or regular contact as part of the person's duties, unless the person is designated to represent the official position of the person's agency.

b. A person subject to this prohibition may not accept employment as a lobbyist for two years after leaving state government if the employment involves lobbying before the agency that the person was employed by or before state agencies, officials, or employees with whom the person had substantial and regular contact as part of the person's former duties except as provided in subrule 8.17(4).

8.17(3) *Lobbying restrictions—state employees with conflicts of interest.* A state employee who is not included in subrule 8.17(1) or 8.17(2) shall not act as a lobbyist in relation to any particular case, proceeding, or application with respect to which the person is directly concerned and personally participates as part of the person's employment, unless the person is designated to represent the official position of the person's agency. Persons subject to this prohibition may not accept employment as a lobbyist for two years after leaving state government if the employment involves lobbying in relation to any particular case, proceeding, or application with respect to which the person was directly concerned and personally participated as part of the person's employment.

8.17(4) *Exception.* As provided in Iowa Code section 68B.5A(7), the prohibition on accepting employment as a lobbyist does not apply to a person who, within two years of leaving state service or employment, is elected to, appointed to, or employed by another office of the state, an office of a political subdivision of the state, or the federal government and represents the position of the new office or employment.

8.17(5) *Complaints.* Complaints or information provided to the board alleging a violation of Iowa Code section 68B.5A by an executive branch official or an executive branch employee shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.5A.

[**ARC 8002B**, IAB 7/29/09, effective 9/2/09]

351—8.18(68B) False communications prohibited.

8.18(1) *False material fact.* An executive branch lobbyist shall not intentionally deceive or attempt to deceive any executive branch official or any executive branch employee in regard to a material fact pertinent to an administrative rule, legislation, or an executive order.

8.18(2) *False communication.* An executive branch lobbyist shall not cause a communication or an executive branch lobbyist registration statement to be sent to an executive branch official or an executive branch employee in the name of either of the following:

a. A fictitious person; or

b. A real person except with the consent of that person.

8.18(3) *Complaints.* Complaints or information provided to the board alleging a violation of this rule by an executive branch lobbyist shall be filed with the board and governed by the procedures in Iowa Code sections 68B.32B through 68B.32D.

This rule is intended to implement Iowa Code section 68B.32A(13).

[Editorial change: IAC Supplement 4/8/09; **ARC 7990B**, IAB 7/29/09, effective 9/2/09]

351—8.19(68B) Advisory opinions. Any person under the board's jurisdiction that is affected by Iowa Code chapter 68B or 351—Chapter 8 may seek an advisory opinion from the board pursuant to rules 351—1.2(68B) and 1.3(68B). The purpose of a board opinion is to apply a statute or rule to a particular factual situation. Advice contained in a board opinion, if followed, constitutes a defense to a subsequently filed complaint.

This rule is intended to implement Iowa Code section 68B.32A(12).

[Editorial change: IAC Supplement 4/8/09]

351—8.20(68B) Retention and availability of filed forms.

8.20(1) *Public record.* All forms filed under this chapter are public records and shall be available in the board office for inspection and copying. A filed form shall be retained by the board for a period of at least five years from the date the form was filed.

8.20(2) *Internet access.* Forms filed under this chapter shall be accessible for viewing via the board's Web site at www.iowa.gov/ethics as follows:

a. A list of registered executive branch lobbyists and executive branch lobbyist clients for the current calendar year and the two previous calendar years.

b. An executive branch lobbyist client report for as long as the general assembly posts the executive branch lobbyist client reports on the general assembly's Web site.

c. A session function registration notice and a session function reporting form for as long as the general assembly posts the session function registration notice and a session function reporting form on the general assembly's Web site.

This rule is intended to implement Iowa Code section 68B.32A(5).

[Editorial change: IAC Supplement 4/8/09; **ARC 8805B**, IAB 6/2/10, effective 7/7/10; **ARC 9983B**, IAB 2/8/12, effective 3/14/12]

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[Filed ARC 9985B (Notice ARC 9680B, IAB 8/24/11), IAB 2/8/12, effective 3/14/12]

◊ Two or more ARCs

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2)*"a," "b,"* and *"c."*

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)*"a"*(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment will not be approved for vaccines which are available through the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health.

g. Payment will not be approved for injections of "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13)*"e."* On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone.

Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs *"b"* through *"f"* shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16)*"b"* shall be attached to the claim for payment and shall be signed by:

(1) The person to be sterilized,

(2) The interpreter, when one was necessary,

(3) The physician, and

(4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

(1) In labor or childbirth, or

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross-reference 78.28(3))

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review

applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The "Preprocedure Surgical Review List" shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the "Preprocedure Surgical Review List" annually. (Cross-reference 78.28(1)*"e."*)

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lemphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin's lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.

(4) Liver transplants for persons with extrahepatic biliary artesia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*)

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*)

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph *"a."*

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term "physician" does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for "covered outpatient drugs" as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including "nonprescription" or "over-the-counter" drugs that may otherwise be dispensed without a prescription, a prescription shall

be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

78.2(5) *Nonprescription drugs.* The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization

Neomycin-bacitracin-polymyxin ointment
Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder

Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8097B**, IAB 9/9/09, effective 11/1/09; **ARC 9175B**, IAB 11/3/10, effective 1/1/11; **ARC 9699B**, IAB 9/7/11, effective 9/1/11; **ARC 9834B**, IAB 11/2/11, effective 11/1/11; **ARC 9882B**, IAB 11/30/11, effective 1/4/12; **ARC 9981B**, IAB 2/8/12, effective 3/14/12]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Foundation for Medical Care (IFMC). All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Readmissions to the same facility due to premature discharge shall not be paid a new DRG. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from IFMC, 6000 Westown Parkway,

Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)*"b"*(1) to (10) except for 78.2(4)*"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)*"b"*(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. Hospitals that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.
Cardiology.
Dialysis.
Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.
Blood bank services.
Cardiology.
Cardiovascular surgery.
Dialysis.
Dietary services.
Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)*"a"* and *"r"* to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective *(a)* as of the date of notice by IFMC that the lower level of care is required or *(b)* for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital's utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the "Outpatient/Same Day Surgery List."

78.3(16) Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

This rule is intended to implement Iowa Code section 249A.4.

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

78.4(1) *Preventive services.* Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of physical or mental disability, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once in a six-month period except for people who need more frequent applications because of physical or mental disability. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

78.4(2) *Diagnostic services.* Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per patient per dentist in a three-year period when the patient has not seen that dentist during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panographic-type radiography with bitewings is considered the same as a complete mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

78.4(3) *Restorative services.* Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per member in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when members are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2)*"e"*)

e. Cast post and core, steel post and composite or amalgam in addition to a crown is payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restorative procedures:

(1) Amalgam or acrylic buildups are considered part of the preparation for the completed restoration.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) A two-surface anterior composite restoration will be payable as a one-surface restoration if it involved the lingual surface.

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) *Periodontal services.* Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.28(2)*"a"*(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)*"a"*(2))

d. Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval based on a written narrative describing medical necessity. (Cross-reference 78.28(2)*"a"*(3))

e. Periodontal maintenance therapy which includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling is a payable service when prior approval has been received. A request for approval must be accompanied by a periodontal treatment plan, a completed copy of a periodontal probe chart which exhibits pocket depths, periodontal history and radiograph(s). Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.28(2)*"a"*(4))

f. Payment as indicated will be made for the following periodontal services:

(1) Periodontal scaling and root planing, gingivoplasty, osseous surgery will be paid per quadrant.

(2) Gingivoplasty will be paid per tooth.

(3) Osseous allograft will be paid as a single site if one site is involved, or if more than one site is involved, payment will be made for multiple sites.

78.4(5) *Endodontic services.* Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment is payable when prior approval has been received. Payment for an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2)*"d"*)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.4(6) *Oral surgery—medically necessary.* Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

j. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

k. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) *Prosthetic services.* Payment may be made for the following prosthetic services:

a. An immediate denture and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a

removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when the member has fewer than eight posterior teeth in occlusion or the member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2)*"c"*(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(2))

e. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth shall be approved for the member whose medical condition precludes the use of a removable partial denture and who has fewer than eight posterior teeth in occlusion or if the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(3))

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines are payable only once per prosthesis every 12 months.

h. Laboratory processed relines are payable only once per prosthesis every 12 months.

i. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

j. Two repairs per prosthesis in a 12-month period are payable.

k. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

l. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

78.4(8) *Orthodontic procedures.* Payment may be made for the following orthodontic procedures:

a. Orthodontic services to treat handicapping malocclusions are payable with prior approval. A score of 26 or above on the index from "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968, is required for approval.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping

malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the Iowa Medicaid enterprise's orthodontic consultant if found to be medically necessary. (Cross-reference 78.28(2)"d")

b. Space management services shall be payable when there is too little dental ridge to accommodate either the number or the size of teeth and if not corrected significant dental disease will result.

c. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required. Pretreatment records are not required.

78.4(9) *Treatment in a hospital.* Payment will be approved for dental treatment rendered a hospitalized patient only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

78.4(10) *Treatment in a nursing facility.* Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

78.4(11) *Office visit.* Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or exams are not billed for that visit.

78.4(12) *Office calls after hours.* Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

78.4(13) *Drugs.* Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

78.4(14) *Services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)*"c."* Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

This rule is intended to implement Iowa Code section 249A.4.

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services are:*

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation.

d. Single vision and multifocal lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Protective lenses are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through six years of age.
3. When there is a prescribed lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Fitting of contact lenses when required following cataract surgery, documented keratoconus, aphakia, or for treatment of acute or chronic eye disease. Up to eight pairs of contact lenses are allowed for children up to one year of age with aphakia. Up to four pairs of contact lenses per year are allowed for children one to three years of age with aphakia.

78.6(2) *Ophthalmic materials.* Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated, manufactured by reputable American manufacturers.

b. Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice.

a. Materials payable by fee schedule are:

(1) Lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Protective lenses and safety frames.

(5) Subnormal visual aids.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

(Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3)*"b"*(4).

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1)*"i."*

78.6(6) *Therapeutically certified optometrists.* Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry to employ the agents and perform the procedures provided by the Iowa Code.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to **78.7(3)** Rescinded IAB 4/3/02, effective 6/1/02.

This rule is intended to implement Iowa Code section 249A.4.

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		
		723.5	Torticollis, unspecified		
		724.01	Spinal stenosis, thoracic region		
		724.02	Spinal stenosis, lumbar region		
		724.4	Thoracic or lumbosacral neuritis or radiculitis		

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		724.6	Disorders of sacrum, ankylosis		
		724.79	Disorders of coccyx, coccygodynia		
		724.8	Other symptoms referable to back, facet syndrome		
		729.1	Myalgia and myositis, unspecified		
		729.4	Fascitis, unspecified		
		738.40	Acquired spondylolisthesis		
		756.12	Spondylolisthesis		
		846.0	Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)		
		846.1	Sprains and strains of sacroiliac region, sacroiliac ligament		
		846.2	Sprains and strains of sacroiliac region, sacrospinatus (ligament)		
		846.3	Sprains and strains of sacroiliac region, sacrotuberous (ligament)		
		846.8	Sprains and strains of sacroiliac region, other specified sites of sacroiliac region		
		847.0	Sprains and strains, neck		
		847.1	Sprains and strains, thoracic		
		847.2	Sprains and strains, lumbar		
		847.3	Sprains and strains, sacrum		
		847.4	Sprains and strains, coccyx		

b. The neuromusculoskeletal conditions listed in the table in paragraph *"a"* generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or

3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph *"c"* of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph *"a"* of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph *"a"* of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or

counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
f. Progress of member in response to treatment.
g. Medical supplies to be furnished.
h. Member's medical condition as reflected by the following information, if applicable:
(1) Dates of prior hospitalization.
(2) Dates of prior surgery.
(3) Date last seen by a physician.
(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
(5) Prognosis.
(6) Functional limitations.
(7) Vital signs reading.
(8) Date of last episode of instability.
(9) Date of last episode of acute recurrence of illness or symptoms.
(10) Medications.
i. Discipline of the person providing the service.
j. Certification period (no more than 62 days).
k. Estimated date of discharge from the hospital or home health agency services, if applicable.
l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of

care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services

furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.*

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

(1) Are reasonable and necessary to the treatment of a member's illness or injury.

(2) Contribute meaningfully to the treatment of the member's condition.

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom which verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) *Vaccines.* Home health agencies which wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 9315B**, IAB 12/29/10, effective 2/2/11]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions, or is primarily for the convenience of a person caring for the patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise, and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators will be maintained on a rental basis for the duration of use.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

78.10(2) *Durable medical equipment.* DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment will not be provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. EXCEPTION: Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility or an intermediate care facility for persons with mental retardation when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that the member has significant hypoxemia as defined by Medicare and evidenced by supporting medical documentation and the member requires oxygen for 12 hours or more per day for at least 30 days. Oxygen prescribed "PRN" or "as necessary" is not allowed. The documentation maintained in the provider record must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

(2) The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.

Automated medication dispenser. See 78.10(2)*"d"* for prior authorization requirements.

Bedpan.

Blood glucose monitors, subject to the limitation in 78.10(2)*"e."*
Blood pressure cuffs.
Cane.
Cardiorespiratory monitor (rental and supplies).
Commode.
Commode pail.
Crutches.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(2)*"d"* for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2)*"d"* for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2)*"d"* for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained at one year of age and at two years of age and documented in the provider record.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician's Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;
2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and

5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

(5) All accessories, disposable supplies, servicing, and repairing of concentrators are included in the monthly Medicaid payment for concentrators.

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

2. The patient's mobility puts the patient at risk for injury.

3. The patient has suffered injuries when getting out of bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient with a diagnosis of a lung disorder if all of the following conditions are met:

1. Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease of lung function.

2. The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

3. Treatment by flutter device failed or is contraindicated.

4. Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

5. All other less costly alternatives have been tried.

(4) Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

1. The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

2. The member is on two or more medications prescribed to be administered more than one time a day.

3. The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

4. Less costly alternatives, such as medisets or telephone reminders, have failed.

(5) Blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. Prior approval shall be granted when the member's medical condition necessitates use of a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department.

e. Blood glucose monitors are covered through the Medicaid program only if:

(1) The monitor is produced by a manufacturer that has a current agreement to provide a rebate to the department for monitors provided through the Medicaid program; or

(2) Prior authorization based on medical necessity is received pursuant to rule 441—79.8(249A) for a monitor produced by a manufacturer that does not have a current rebate agreement with the department.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a patient prior to the time the patient undergoes a procedure which will make necessary the use of the device.

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3)*"c"* for prior approval requirements.

(4) Enteral delivery supplies and products. See 78.10(3)*"c"* for prior approval requirements.

(5) Hearing aids. See rule 441—78.14(249A).

(6) Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded.

(7) Orthotic devices. See 78.10(3)*"d"* for limitations on coverage of cranial orthotic devices.

(8) Ostomy appliances.

(9) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(10) Prosthetic shoes. See rule 441—78.15(249A).

(11) Tracheotomy tubes.

(12) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(4))

c. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1)*"c"*)

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity

for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member. Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is between 6 and 18 months of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the

preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic blood glucose test strips, subject to the limitation in 78.10(4)*"c."*

Diabetic supplies, other than blood glucose test strips (needles, syringes, and diabetic urine test supplies).

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

Diabetic supplies (needles and syringes, blood glucose test strips and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

c. Diabetic blood glucose test strips are covered through the Medicaid program only if:

(1) The strips are produced by a manufacturer that has a current agreement to provide a rebate to the department for test strips provided through the Medicaid program, or

(2) Prior authorization is received pursuant to rule 441—79.8(249A) for test strips produced by a manufacturer that does not have a current rebate agreement with the department, based on medical necessity.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 8993B**, IAB 8/11/10, effective 10/1/10; **ARC 9256B**, IAB 12/1/10, effective 1/1/11]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved

only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

This rule is intended to implement Iowa Code section 249A.4.

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of an Axis I psychological disorder, subject to the limitations in this rule.

78.12(1) *Definitions.*

"Axis I disorder" means a diagnosed mental disorder, except for personality disorders and mental retardation, as set forth in the "Diagnostic and Statistical Manual IV-TR," Fourth Edition.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;

2. Improving a member's health and well-being related to the member's Axis I disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and

3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), an advanced registered nurse practitioner (ARNP), a psychologist,

a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

1. Is licensed by the applicable state authority for that profession;
2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and
3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

78.12(2) *Covered services.*

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and

2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;

2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,

2. Conflict resolution skills,

3. Daily living skills,

4. Employment-related skills,

5. Interpersonal relationship skills,

6. Problem-solving skills, and

7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,

2. Behavioral support in the community,

3. Specific skills impaired due to the member's mental illness, and

4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

b. Subsequent plans. The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)*"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)*"c"*(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by an Axis I disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11]

441—78.13(249A) Nonemergency medical transportation. Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, shall be provided through the broker designated by the department pursuant to a contract between the department and the broker, as specified in this rule.

78.13(1) *Member request.* When a member needs nonemergency transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker shall establish and publicize the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

78.13(2) *Necessary services.* Transportation shall be provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

78.13(3) *Access to free transportation.* Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

78.13(4) *Closest medical provider.* Transportation beyond 20 miles (one way) shall be provided only to the closest qualified provider unless:

a. The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or

b. The additional cost of transportation to the provider requested by the member is medically justified based on:

(1) A previous relationship between the member and the requested provider,

(2) Prior experience of the member with closer providers, or

(3) Special expertise or experience of the requested provider.

78.13(5) *Coverage.* Based on the information provided by the member and the provisions of this rule, the broker shall arrange and reimburse for the most economical form of transportation appropriate to the needs of the member.

a. The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use.

b. The broker may arrange and reimburse for transportation by arranging to reimburse the member for transportation expenses. In that case, the member shall submit transportation expenses to the broker on Form 470-0386, Medical Transportation Claim, or an equivalent electronic form.

c. When a member is unable to travel alone due to age or due to physical or mental incapacity, the broker shall provide for the expenses of an attendant.

d. The broker shall provide for meals, lodging, and other incidental transportation expenses required for the member and for any attendant required due to the age or incapacity of the member in connection with transportation provided under this rule.

78.13(6) *Exceptions for nursing facility residents.*

a. Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) shall not be provided through the broker but shall be the responsibility of the nursing facility.

b. Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) shall be provided through the broker, but the nursing facility shall contact the broker on behalf of the resident.

78.13(7) *Grievances.* Pursuant to its contract with the department, the broker shall establish an internal grievance procedure for members and transportation providers. Members who have exhausted the grievance process may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person." For transportation providers, the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross-reference 78.28(4)*"a"*)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4)*"b"*):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output

shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8008B**, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.
(2) Pain.
(3) Tissue breakdown or a high probability of tissue breakdown.
(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

This rule is intended to implement Iowa Code section 249A.4.

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* to *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio.

Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours

in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist

of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

This rule is intended to implement Iowa Code section 249A.4.

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as screening center services. Screening centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid members.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Six screenings in the first year of life.

(2) Four screenings between the ages of 1 and 2.

(3) One screening a year at ages 3, 4, 5, and 6.

(4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the recipient's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the

same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1)*"b"*(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.
(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
(11) A brief summary of the initial evaluation or baseline.
(12) The patient's prognosis.
(13) The services to be rendered.
(14) The frequency of the services and discipline of the person providing the service.
(15) The anticipated duration of the services and the estimated date of discharge (if applicable).
(16) Assistive devices to be used.
(17) Functional limitations.
(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
(20) Quantitative, measurable, short-term and long-term functional goals.
(21) The period of time of a session.
(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:
(1) To whom the services were provided (patient, family member, etc.).
(2) Prior teaching, training, or counseling provided.
(3) The medical necessity of the rendered services.
(4) The identification of specific services and goals.
(5) The date of the start of the services.
(6) The frequency of the services.
(7) Progress in response to the services.
(8) The estimated length of time the services are needed.

This rule is intended to implement Iowa Code section 249A.4.

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as rural health center services. Rural health clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children

program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

This rule is intended to implement Iowa Code section 249A.4.

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as family planning clinic services. Family planning clinics that wish to administer those vaccines for Medicaid members who receive services at the clinic shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

This rule is intended to implement Iowa Code section 249A.4.

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as clinic services. Clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

This rule is intended to implement Iowa Code section 249A.4.

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as maternal health center services. Maternal health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid members.

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies*. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.
(6) Infant care.
(7) Grief support for unhealthy outcome.
(8) Parenting of a preterm infant.
(9) Identification of and referral to community resources as needed.

This rule is intended to implement Iowa Code section 249A.4.

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8205B**, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services.

78.27(1) *Definitions.*

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"ISIS" means the department's individualized services information system.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member's case manager has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager shall establish an interdisciplinary team for the member. The team shall include the case manager and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial service plan and annual updates to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written case plan must be completed, signed and dated by the case manager or service worker within 30 calendar days after plan approval.

(10) Any changes to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A service plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)*"e."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities of daily living;

(3) Community inclusion;

(4) Transportation;

(5) Adult educational supports;

(6) Social and leisure skill development;

(7) Personal care; and

(8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;

(2) Physical and emotional health and development;

(3) Language and communication development;

(4) Cognitive functioning;

(5) Socialization and community integration;

(6) Functional skill development;

(7) Behavior management;

(8) Responsibility and self-direction;

(9) Daily living activities;

(10) Self-advocacy skills; or

(11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's

comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or "enclave" setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member's job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) Rescinded IAB 12/29/10, effective 1/1/11.

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) *County reimbursement.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 9311B**, IAB 12/29/10, effective 1/1/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11]

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. (Cross-reference 78.10(2)*"b"*) Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time a day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition. (Cross-reference 78.10(3)*"c"*(2))

(1) A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3)*"c"*(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe

current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department's consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

(1) The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The patient's mobility puts the patient at risk for injury.

(3) The patient has suffered injuries when getting out of bed.

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2)*"c"*)

i. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for oral nutritional products when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before initiation of the vest demonstrate an overall significant decrease of lung function.

(2) The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

k. Prior authorization is required for blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. The department shall approve payment when a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department are medically necessary.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4)*"b"*)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4)*"c"*)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4)*"d"*)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4)*"e"*)

b. Surgical endodontic treatment which includes an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.4(5)*"c"*)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion or the member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7)*"c"*)

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative

materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"d"*)

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"e"*)

(4) Dental implants and related services will be authorized when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

d. Orthodontic services to treat a handicapping malocclusion are payable with prior approval. A score of 26 or above on the index from "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968, is required for approval.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

1. Degree of malalignment;
2. Missing teeth;
3. Angle classification;
4. Overjet and overbite;
5. Openbite; and
6. Crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise medical services unit.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department's orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8)*"a"*)

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3)*"d"*)

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization

shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3)*"b"*)

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to

administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

This rule is intended to implement Iowa Code section 249A.4.

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Hospital outpatient programs that wish to administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. In lieu of payment, vaccines available through the Vaccines for Children program shall be accessed from the department of public health for Medicaid members. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary

self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph *"a,"* subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs

are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

This rule is intended to implement Iowa Code section 249A.4.

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

This rule is intended to implement Iowa Code section 249A.4.

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. Meal preparation planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would

provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with

understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.34(9) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

(1) Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's

assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS ill and handicapped waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4.

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate

direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.

2. The individual or the individual's representative revokes the election.

3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.

4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is one hour.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.37(16) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment

factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16)*"b"*(2) or the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual

budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)*"d."* The savings plan shall meet the requirements in paragraph 78.37(16)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds

from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full

day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.38(9) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)*"b"*(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9)*"d."* The savings plan shall meet the requirements in paragraph 78.38(9)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter)]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

This rule is intended to implement Iowa Code section 249A.4.

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) *Vaccine administration.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

78.40(5) *Prenatal risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the member in achieving the member's life goals. The services, amount and supports provided under the HCBS intellectual disability waiver shall be delivered in the least restrictive environment and in conformity with the member's service plan. Reimbursement shall not be available under the waiver for any services that the member can obtain through the Medicaid state plan. All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph 78.41(1)*"f"*(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the member's waiver year.

e. The service shall be identified in the member's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services or with supported community living, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

g. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.41(8).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.

9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.

10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private

insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph *"b,"* the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)*"d."* The savings plan shall meet the requirements in paragraph 78.41(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the vaccines for children program administered by the department of public health if the pharmacy is enrolled in the vaccines for children program. No payment will be made for the vaccine.

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph 78.43(2)*"e"*(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.43(4) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the consumer for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other

Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The case

manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.43(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15)*"b*"(2) or the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)*"d."* The savings plan shall meet the requirements in paragraph 78.43(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

This rule is intended to implement Iowa Code section 249A.4.

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

a. Providers must demonstrate proficiency in delivery of the services in the member's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training.

(1) All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan.

(2) The member shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the member.

b. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

c. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of members unable to eat solid foods.

(2) Assistance with intravenous therapy which is administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood altering or psychotropic drugs or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

d. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the person or agency that will provide the components of the attendant care services.

(2) Determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

(1) Provide for the health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

78.46(6) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6)*"b"*(2) or the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and

approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6)*"d."* The savings plan shall meet the requirements in paragraph 78.46(6)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;
(2) The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

This rule is intended to implement Iowa Code section 249A.4.

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

This rule is intended to implement Iowa Code section 249A.4.

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the consumer and the consumer's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the consumer's interdisciplinary team pursuant to 441—83.127(249A).

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per consumer per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)*"a"*(1).

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the consumer to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The "usual caregiver" means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

a. Respite care shall not be provided to members during the hours in which the usual caregiver is employed, except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one member. The member has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

e. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

f. A unit of service is one hour.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12]

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◊ Two or more ARCs

1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

3 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

7 July 1, 2009, effective date of amendments to 78.27(2)*"d"* delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

8 May 11, 2011, effective date of 78.34(5)*"d,"* 78.38(5)*"h,"* 78.41(2)*"g,"* 78.43(3)*"d,"* and 78.52(5)*"a"* delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1)*"e"*(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	$50.57 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

Provider category	Basis of reimbursement	Upper limit
		3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers effective 7/1/11: Provider's rate in effect 11/30/09. If no 11/30/09 rate: Veterans Administration contract rate or $22.12 per half-day, $44.03 per full day, or $66.03 per extended day if no Veterans Administration contract. For intellectual disability waiver: County contract rate or, effective 7/1/11 in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, $29.47 per half-day, $58.83 per full day, or $75.00 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Initial one-time fee: $49.53. Ongoing monthly fee: $38.52.
Portable locator system	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: One equipment purchase: $307.69. Initial one-time fee: $49.53. Ongoing monthly fee: $38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $19.81 per hour.

Provider category	Basis of reimbursement	Upper limit
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $82.92 per visit. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $82.92 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed $296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $33.75 per hour not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate.
Camps	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with mental retardation	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $7.71 per half hour.

Provider category	Basis of reimbursement	Upper limit
8. Home-delivered meals	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $7.71 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver: $1,010 lifetime maximum. For intellectual disability waiver: $5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6,060 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: $8.25 per unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/11: $110.05 per unit.
14. Senior companion	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: $6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $20.20 per hour not to exceed $116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $1,117 per calendar month. When prorated per day for a partial month, $36.71 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, $13.47 per hour not to exceed $78.56 per day.
16. Counseling		
Individual:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $10.79 per unit.

Provider category	Basis of reimbursement	Upper limit
Group:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $43.14 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour, $78.88 per day not to exceed the maximum daily ICF/MR rate.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour. Maximum of 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: $34.98 per hour for all activities other than personal care and services in an enclave setting. $19.81 per hour for personal care. $6.19 per hour for services in an enclave setting. $2,883.71 per month for total service. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	$6,060 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $43.14 per hour.

Provider category	Basis of reimbursement	Upper limit
23. Prevocational services	Fee schedule	For the brain injury waiver effective 7/1/11: $48.22 per day, $24.11 per half-day, or $13.21 per hour. For the intellectual disability waiver effective 7/1/11: County contract rate or, in absence of a contract rate, $48.22 per day, $24.11 per half-day, or $13.21 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Child development home or center	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.12 per hour.
Supported community living provider	Retrospectively limited prospective rate	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $34.98 per hour, not to exceed the maximum ICF/MR rate per day.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: The maximum ICF/MR rate per day.
26. Day habilitation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate: $13.21 per hour, $32.15 per half-day, or $64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $34.98 per hour.
29. In-home family therapy	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $93.63 per hour.
30. Financial management services	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $65.65 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: $15.15 per hour.

Provider category	Basis of reimbursement	Upper limit
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.

Provider category	Basis of reimbursement	Upper limit
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"* (1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
	The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.

Provider category	Basis of reimbursement	Upper limit
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	$6.20 dispensing fee effective 8/1/11. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Effective 8/1/11: Fee schedule in effect 11/30/09.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

a. Payment is made for facility services on a fee schedule determined by the department and published on the department's Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report" means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients

under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing

implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)*"y."* Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals

certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital's fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state's fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is $26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. Non-state-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable,

and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard

deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5)*"u"* or 79.1(5)*"v"* cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory

procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Payment adjustment for services rendered in facility settings. When a service is rendered in a facility setting, the fee schedule amount paid to physicians based on paragraph 79.1(7)*"a"* shall be adjusted by a percentage differential that is equal to the percentage difference between the Medicare nonfacility and facility fee schedule amounts for Iowa. For the purpose of this provision, a "facility" place of service (POS) is defined as any of the following:

(1) Hospital inpatient unit (POS 21).
(2) Hospital outpatient unit (POS 22).
(3) Hospital emergency room (POS 23).
(4) Ambulatory surgical center (POS 24).
(5) Skilled nursing facility (POS 31).
(6) Inpatient psychiatric facility (POS 51).
(7) Community mental health center (POS 53).
(8) Comprehensive inpatient rehabilitation (POS 61).

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph *"g."*

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph *"g."*

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g"*; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered on or after August 1, 2011, the professional dispensing fee is $6.20 or the pharmacy's usual and customary fee, whichever is lower.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)*"a"*(3) and 79.1(8)*"c"* and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"*78.37(16)*"b,"*78.38(9)*"b,"*78.41(15)*"b,"*78.43(15)*"b,"* or 78.46(6)*"b."*

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to $10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than $25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed $1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 102.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 102.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over

30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"GME/DSH fund apportionment claim set" means the hospital's applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

"GME/DSH fund implementation year" means 2009.

"Graduate medical education and disproportionate share fund" or *"GME/DSH fund"* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular

OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.

Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;

2. Recompute Medicaid payments due based on the recalculated Medicaid rates;

3. Recoup any previous overpayments; and

4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members not participating in the MediPASS program who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993.

Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.
2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.
3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. $9,900,000.

(2) One-twelfth of the $9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the $9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall

request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit

of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.
2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed $1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24)*"b,"* the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the

amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled int he Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) *Grounds for sanctioning providers.* Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over $500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

(1) Seriousness of the offense.
(2) Extent of violations.
(3) History of prior violations.
(4) Prior imposition of sanctions.
(5) Prior provision of provider education.
(6) Provider willingness to obey program rules.
(7) Whether a lesser sanction will be sufficient to remedy the problem.
(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5)*"c"* are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,
b. The known dollar value of the discrepancies or violations,
c. The method of computing the dollar value,
d. Notification of further actions to be taken or sanctions to be imposed by the department, and
e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a

final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

This rule is intended to implement Iowa Code section 249A.4.

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.

12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.

2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.

3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.

4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).

5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Any supplies dispensed as part of the service.

7. The first and last name and professional credentials, if any, of the person providing the service.

8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.

2. Nursing facility physician order.

3. Telephone order.

4. Pharmacy notes.

5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.

2. Anesthesia notes and records.

3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.

2. Certifying physician statement.

3. Prescription or order form.

(5) Certified registered nurse anesthetist services:
1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.
(6) Other advanced registered nurse practitioner services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
(7) Optometrist and optician services:
1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.
(8) Psychologist services:
1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.
(9) Clinic services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.
(10) Services provided by rural health clinics or federally qualified health centers:
1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.
(11) Services provided by community mental health centers:
1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.
(12) Screening center services:
1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.
(13) Family planning services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.
(14) Maternal health center services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Form 470-2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
2. Physician orders.
3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.
2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.

4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:

1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:

1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.

(25) Behavioral health intervention:

1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:

1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:

1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:

1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:

1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:

1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:

1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.

4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
2. Documentation of hearing aid evaluation and selection (Form 470-0828).
3. Waiver of informed consent.
4. Prior authorization documentation.
5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) *Availability.* Rescinded IAB 1/30/08, effective 4/1/08.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 8262B**, IAB 11/4/09, effective 12/9/09; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
Reviewer Name & Phone Number: _____
Provider Name: _____
Provider Number: _____
Provider Type: _____

Please sign this form and return it with the information requested.
Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.
Please send copies. Do not send original records.
If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number

470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2and 3.

79.7(3) *Expenses, staff support, and technical assistance.* Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) *Meetings.* The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) *Duties.*

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

This rule is intended to implement Iowa Code section 249A.4.

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

d. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) *State elections.* In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

(1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or

(2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the hospital fiscal year.

79.16(2) *Eligible providers.* To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.
2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa

Medicaid portal access (IMPA) Web site at https://secureapp.dhs.state.ia.us/impa/. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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◊ Two or more ARCs

1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

3 Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

7 July 1, 2009, effective date of amendments to 79.1(1)*"d,"* 79.1(2), and 79.1(24)*"a"*(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

CHAPTER 92
IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

"Enrollment period" means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Group health insurance" means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Initial application" means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code section 249J.6.

"Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1)*"b."*

"Nonparticipating provider" means a hospital that is located in Iowa and licensed pursuant to Iowa Code chapter 135B but that is not an IowaCare provider pursuant to subrule 92.8(1).

"Provider-directed care coordination services" means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care

are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.
[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) *Persons covered.* Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph *"b."*

92.2(2) *Citizenship.* To be eligible for IowaCare benefits, a person must meet the requirements in 441—subrule 75.11(2). A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) *Other disqualification.* A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) *Group health insurance.* A person who has access to group health insurance is not eligible for IowaCare. The department shall use Form 470-4542, IowaCare Insurance Information Request, to obtain information to confirm the status of an IowaCare member's group health insurance. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) *Payment of assessed premiums.* IowaCare will be canceled if premiums are not paid in accordance with 441—92.7(249A,249J). However, an application for IowaCare shall not be affected by any unpaid premiums from any previous certification period.

92.2(6) *Availability of funds.* Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).
[**ARC 8505B**, IAB 2/10/10, effective 4/1/10; **ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) and has income over 150 percent of the federal poverty level shall also sign Form 470-4194, IowaCare Premium Agreement, and submit it within ten days of the department's request.

92.3(2) A new application is required for each certification period.
[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9982B**, IAB 2/8/12, effective 4/1/12]

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) *Verification.* Applicants seeking eligibility under 92.2(1)*"b"* shall provide verification of medical expenses as required under 92.5(5)*"b."* IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

c. If benefits are denied or canceled for failure to provide information and the information is provided within 14 calendar days of the effective date of the denial or cancellation, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information.

92.4(2) *Screening for full Medicaid.* The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) *Time limit for decision.* The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).
[**ARC 8500B**, IAB 2/10/10, effective 3/1/10]

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant's household as of the date of decision. To be eligible, the household's income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) *Household size.* The household size shall include the applicant and the applicant's dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant's spouse shall not be considered absent from the home when:

(1) The spouse's absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

b. The conditions described in 441—paragraph 75.53(4)*"b"* shall be applied to determine whether a person's absence is temporary.

92.5(2) *Self-declaration of income.* Applicants shall self-declare the household's future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household's monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) *Earned income.* All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1)*"b"*(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining the net profit counted as earned income from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3)*"b."*

92.5(4) *Unearned income.* Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph *"b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m," "p," "q," "r," "t," "u," "v," "w," "x," "y," "z,"* or *"aa"*; or

b. 441—subrule 75.57(7), paragraph *"a," "b," "c," "d," "e," "f," "g," "h," "i," "j," "k," "l," "m,"* or *"q."*

92.5(5) *Deductions.* The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1)*"b,"* medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

(1) Health insurance premiums, deductibles, or coinsurance charges; and

(2) Medical and dental expenses.

92.5(6) *Disregard of changes.* A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

92.5(7) *Unearned nonrecurring lump-sum income.* All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) *Earned lump-sum income.* Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) *Certification period.* IowaCare eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The certification period shall continue for 12 consecutive months. EXCEPTIONS:

a. For women and newborns eligible under 92.2(1)*"b"* or *"c,"* the certification period shall continue until 60 days after the birth of the child.

b. Certification periods may be adjusted if two or more IowaCare members who were in two households are combined into one household for premium purposes.

92.6(2) *Retroactive eligibility.* IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) *Care provided before eligibility.* No payment shall be made for medical care received before the effective date of eligibility.

92.6(4) *Reinstatement.* Eligibility for IowaCare may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. When eligibility can be reestablished, assistance shall be reinstated with an effective date of the first day of the month following the month of cancellation.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1)*"c"* and members in households that include a considered person who pays a Medicaid premium, shall be assessed a sliding-scale monthly premium. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) *Premium amount.* The monthly premium amount shall be established for the certification period determined pursuant to subrule 92.6(1) beginning with the first month of eligibility, based on projected monthly income for 12 months. On an initial application, no premium shall be assessed for months of eligibility before and including the month of decision, including the retroactive month.

a. The monthly premium is based on the household's countable monthly income as a percentage of the federal poverty level for a household of that size. If there is more than one IowaCare member in a household, a single premium is established for coverage of all of the members in the household. Effective for applications and recertifications received on or after June 1, 2011, premiums are as follows:

When there is one IowaCare member in the household and the household's income is at or below:	The member's premium amount is:
150% of federal poverty level	$0
160% of federal poverty level	$50
170% of federal poverty level	$54
180% of federal poverty level	$57
190% of federal poverty level	$60
200% of federal poverty level	$63

When there are two or more IowaCare members in the household and the household's income is at or below:	The household's premium amount is:
150% of federal poverty level	$0
160% of federal poverty level	$68
170% of federal poverty level	$72
180% of federal poverty level	$77
190% of federal poverty level	$81
200% of federal poverty level	$85

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment of the federal poverty level for a household of one if there is one IowaCare member in the household or of the federal poverty level for a household of two if there are two or more IowaCare members in the household.

(1) Households with income at or below 150 percent of the poverty level are not subject to a premium.

(2) Premiums for households with income over 150 percent of the poverty level are 3.5 percent of the lowest applicable income level. The department will update these amounts effective the second month after the month federal poverty level guidelines are released.

c. The cost of HAWK-I premiums paid for household members shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a certification period shall not be increased due to an increase in household income or a change in household size.

e. The premium may be reduced prospectively during the certification period if a member declares a reduction in projected average monthly household income or an increase in household size or is granted a hardship exemption.

92.7(2) *Billing and payment.* Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. Method of payment. Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

b. Due date. When the department notifies a member of the amount of the premium, the member or household shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. Application of payment. The department shall apply premium payments received to the oldest unpaid month in the current certification period. When premiums for all months in the certification period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) *Hardship exemption.* A member or household that submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph *"c."*

a. If the statement is not received by five working days after the premium due date, the member or household shall be obligated to pay the premium.

b. If the statement is timely submitted with a partial payment, exemption shall be granted for the balance owed for that month.

c. A member or household shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) *Failure to pay premium.* If the member or household fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective 60 days after the due date and shall refer the unpaid premiums for collection. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) *Refund of premium.* When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph *"a,"* premiums paid for any period after the cancellation date shall be refunded, except to the extent that premiums are still due for any household members whose IowaCare coverage is not canceled.

a. Premiums may be refunded when a member's IowaCare coverage is canceled because the member:

(1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);

(2) Has access to group health insurance coverage as defined in subrule 92.2(4);

(3) Reaches age 65;

(4) Dies; or

(5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for a person who is not receiving IowaCare benefits shall be refunded:

(1) Two calendar months after eligibility ended unless an application or reapplication is pending, or

(2) Upon the person's request.

d. Any excess premium received for an IowaCare member shall be refunded:

(1) After two calendar months of a zero premium, or

(2) Upon the member's request.

[**ARC 7667B**, IAB 4/8/09, effective 4/1/09; **ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9532B**, IAB 6/1/11, effective 7/6/11; **ARC 9982B**, IAB 2/8/12, effective 4/1/12]

441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) *Provider network.* Except as provided in subrules 92.8(3) through 92.8(6), IowaCare members shall have medical assistance only for services provided to the member by:

a. The University of Iowa Hospitals and Clinics; or

b. Broadlawns Medical Center in Des Moines; or

c. A federally qualified health center that the department has designated as part of the IowaCare network using a phased-in approach based on the degree to which the area is underserved, medical home readiness, and the availability of funds; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

92.8(2) *Covered services.* Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78 or 441—79.9(249A) and to medical home services required by subrule 92.8(7). All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) *Obstetric and newborn coverage.* IowaCare members who qualify under 92.2(1)*"b"* or *"c"* are also eligible for the services specified in paragraph *"a"* or *"b"* from the providers specified in paragraph *"c"* or *"d."*

a. Covered services for pregnant women shall be limited to:

(1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.

(2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.

(3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.

b. Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.

(1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.

(2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).

c. For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics.

d. Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) *Routine preventive medical examinations.* A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1)*"b"* or *"c"* and who have not been enrolled with a medical home are eligible to receive routine preventive medical examinations from:

(1) Any provider specified under subrule 92.8(1), or

(2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center that has not been designated as an IowaCare provider pursuant to paragraph 92.8(1)*"c."* Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

92.8(5) *Drugs for smoking cessation.* IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

92.8(6) *Medical home.* As a condition of participation in the IowaCare program, network providers designated pursuant to subrule 92.8(1) must also qualify as medical homes, pursuant to Iowa Code chapter 135, division XXII.

a. The provider shall meet medical home standards. If the Iowa department of public health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to IowaCare medical home providers and shall take precedence over the requirements in this paragraph. At a minimum, medical homes shall:

(1) Have National Committee for Quality Assurance (NCQA) Level 1 certification or equivalent certification. Effective July 1, 2011, medical homes that achieve a higher level of accreditation from NCQA or equivalent shall be designated as such for purposes of payment.

(2) Provide provider-directed care coordination services.

(3) Provide members with access to health care and information.

(4) Provide wellness and disease prevention services.

(5) Create and maintain chronic disease information in a searchable disease registry.

(6) Demonstrate evidence of implementation of an electronic health record system.

(7) Participate in and report on quality improvement processes.

b. The provider shall execute a contract with the department to be an IowaCare medical home and receive enhanced medical home reimbursements pursuant to subrule 92.9(4). The contract shall include performance measurements and specify expectations and standards for a medical home.

c. If an IowaCare member resides in a designated county near a designated medical home provider, the department shall assign the member to that provider. If an IowaCare member who is assigned to a medical home chooses to go to another provider without a referral from the medical home:

(1) The service is not covered by the IowaCare program, and

(2) The provider may bill the member according to the provider's established criteria for billing other patients.

92.8(7) *Services from nonparticipating providers.*

a. A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

(1) The patient is enrolled in IowaCare pursuant to the Iowa Medicaid enterprise eligibility verification system at the time the services are delivered.

(2) The services are emergency services, as designated by the department, and it is not medically possible to postpone provision of those services.

(3) It is not medically possible to transfer the member to an IowaCare provider, or the IowaCare provider does not have sufficient capacity to accept the member.

(4) The provision of emergency services is followed by an inpatient admission at the nonparticipating provider.

(5) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services.

b. If the conditions listed in paragraph *"a"* are met as specified, a nonparticipating provider may be reimbursed for covered services provided to the member from the point of emergency room admission to the point of discharge or transfer from the inpatient unit, up to the amount appropriated. This reimbursement does not include emergency or nonemergency transportation services.

c. Care coordination pool. A care coordination pool is established to provide payment for medically necessary services provided to IowaCare members for continuation of care provided by a participating IowaCare hospital. Reimbursement is available from designated care coordination pool funding subject to the following conditions:

(1) Payment may be made for continuing care that is related to an IowaCare member's hospital services as determined in a referral from the participating IowaCare hospital.

(2) Payment for continuing care is available to providers that are enrolled in the Iowa medical assistance program, regardless of whether the provider is a participating provider for IowaCare and regardless of the member's county of residence or medical home assignment.

(3) A provider of continuing care that does not participate in the IowaCare program must include information regarding the referral on the claim form.

(4) Payment shall be made only for services that are not otherwise covered under the IowaCare program. Payment shall not be made for services that would normally be provided by the IowaCare provider to other non-IowaCare patients.

(5) The type, scope, and duration of payable services shall be limited as determined by the department. Payable services are limited to:

1. Durable medical equipment.
2. Home health services.
3. Rehabilitation and therapy services, including intravenous antibiotics and parenteral therapy delivered at home.

(6) Types of items or services that are not covered include, but are not limited to:

1. Adult diapers.
2. Air compressors.
3. Bedside commodes.

4. Blood pressure kits or machines.
5. Cardiac event monitors.
6. Continuous passive motion machines.
7. Continuous positive air pressure (CPAP) machines.
8. Dental care (nonsurgical).
9. Eyeglasses, contact lenses, and eye prostheses.
10. Gel shoe inserts.
11. Hearing aids.
12. Heated oxygen.
13. Laboratory tests and radiology procedures.
14. Oral supplemental formula.
15. Outpatient pharmaceuticals not specifically identified in 92.8(7)*"c"*(5) above.
16. Ted hose, Sigvaris stockings, or Jobst stockings.
17. Tennis shoes.
18. Transcutaneous electrical nerve stimulation (TENS) units.
19. Transportation.
20. Work boots.

(7) All other medical assistance program policies affecting the payable services shall apply, including those regarding prior authorization and level of care determination.

(8) Payment is limited to the amount of available funds designated for the care coordination pool.

d. Laboratory test and radiology pool. A funding pool is established to provide payment for medically necessary laboratory tests and radiology services provided to enrolled IowaCare members when authorized by a federally qualified health center that has been designated by the department as part of the IowaCare regional provider network. Payment from the pool shall be subject to the following conditions and limitations:

(1) Payment may be made only for laboratory tests or radiology services which the participating federally qualified health center does not otherwise have the means to provide on site.

(2) Each participating federally qualified health center shall designate no more than four laboratory testing facilities and no more than four radiology facilities to which the center will refer IowaCare patients for these services. The designated providers must participate in the Iowa medical assistance program. Payment shall be made only to the designated providers.

(3) The designated provider must obtain a referral from the participating federally qualified health center for the services and must include information regarding the referral on the claim form.

(4) All other medical assistance policies for coverage of laboratory and radiology services shall apply, including requirements for prior authorization.

(5) Payment is limited to the amount of available funds designated for the laboratory test and radiology pool. If the amount appropriated for the pool is exhausted, laboratory tests and radiology services ordered by a participating federally qualified health center shall be provided or coordinated by the center.

92.8(8) *Referral protocols.* When an IowaCare primary care provider refers the member to an IowaCare specialty provider, the following conditions shall apply:

a. By January 1, 2012, IowaCare providers shall ensure that referral and patient access processes for IowaCare members are no more restrictive than the processes required for any other payor.

b. After an IowaCare provider makes a referral, the IowaCare provider receiving the referral shall report the following information to the referring provider in a manner chosen by the provider receiving the referral:

(1) The date an appointment has been scheduled. The appointment date shall be reported to the referring provider within 15 calendar days of receiving the referral. If the referral is denied, the receiving provider shall offer a consultation by telephone, fax, E-mail, or Internet regarding the reason for the denial.

(2) If authorized by the IowaCare member, the outcome of the appointment, including whether the appointment was kept, the treatment plan, and any follow-up instructions. This report shall be made no later than 15 calendar days following the appointment date.

c. IowaCare providers shall work together to address any communication or coordination issues that arise. By October 1, 2011, IowaCare providers shall jointly develop and implement:

(1) A process to resolve disputes regarding care needs, payment and referrals that includes regular meetings between providers.

(2) A process to identify and address quality improvements with a goal to improve coordination of care between primary, specialty and hospital care. This process shall be monitored by the department but be managed and staffed by the providers.

92.8(9) *Outpatient prescription drugs and podiatry services provided by Broadlawns Medical Center.* Effective November 1, 2011, Broadlawns Medical Center shall be reimbursed for outpatient prescription drugs and podiatry services provided to members of the expansion population. Payment is limited to the amount of funds appropriated for this purpose.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10; **ARC 9728B**, IAB 9/7/11, effective 9/1/11; **ARC 9890B**, IAB 11/30/11, effective 1/4/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12]

441—92.9(249A,249J) Claims and reimbursement methodologies.

92.9(1) *Claims.* Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

92.9(2) *Payment for hospital services provided by IowaCare network.* Effective July 1, 2010:

a. Inpatient hospital services provided by University of Iowa Hospitals and Clinics will be paid based on 100 percent of reasonable and allowable costs.

(1) An interim rate based on the Medicaid reimbursement rates and methodologies as of November 30, 2009, shall be used to price submitted claims.

(2) At the end of the cost reporting period, a reconciliation will be performed based on the hospital's CMS-2552 cost report as filed for the payment period and IowaCare claims data as extracted by the department from the Medicaid management information system. The aggregate payments under the interim methodology will be determined and compared to the IowaCare program costs as determined from the hospital's cost report. For purposes of this rule, aggregate payments include amounts received for the IowaCare program, outlier payments, and patient and third-party payments up to the allowed amount.

(3) If the aggregate payments exceed the hospital's IowaCare costs, the amount by which payments exceed actual costs will be requested and collected from the hospitals.

(4) If the aggregate payments are less than actual IowaCare costs, an additional payment equal to the difference will be made to the hospital.

b. Inpatient hospital services provided by Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

c. Outpatient hospital services provided by University of Iowa Hospitals and Clinics or Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

92.9(3) *Payment for nonhospital services provided by IowaCare network.* Effective July 1, 2010, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts in effect on November 30, 2009, with the following exceptions:

a. For preventive examination codes, the fee schedule amounts shall be based on the Medicaid physician fee schedule in effect on the date of service.

b. Physician services provided to IowaCare members in a federally qualified health center shall be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

c. Physician services provided by University of Iowa Hospitals and Clinics physicians to IowaCare members will be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

92.9(4) *Medical home payments.*

a. In addition to any other IowaCare reimbursement, IowaCare providers that meet the medical home standards pursuant to subrule 92.8(6) and have contracted with the department shall receive a monthly medical home payment for each member assigned to the medical home by the department. The medical home payment shall begin the first day of the month following the member's assignment to the medical home.

(1) The medical home payment will be on a per-member, per-month basis in an amount determined by the department, but no more than $4 per member, per month.

(2) Effective July 1, 2011, the department shall implement a tiered per-member, per-month payment method that is based on the medical home's certification level as designated by a nationally recognized medical home accreditation organization.

b. IowaCare medical homes shall be eligible for a performance payment for achieving medical home performance benchmarks designated by the department as specified in the provider's contract with the department. The performance payment shall be paid by October 31 following the end of the state fiscal year and is in addition to any other IowaCare reimbursement.

92.9(5) *Payment for services provided by nonparticipating hospitals.* Nonparticipating hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on December 1, 2009, up to the amount appropriated to the nonparticipating provider reimbursement fund created in 2009 Iowa Code Supplement section 249J.24A. No payment shall be made after appropriated funds are exhausted.

92.9(6) *Payment for services provided by other nonparticipating providers.* Nonparticipating providers other than hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on the date of service.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.10(249A,249J) Reporting changes.

92.10(1) *Reporting requirements.* A member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member obtains other health insurance coverage.

92.10(2) *Untimely report.* When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) *Effective date of change.* After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or

b. The certification has expired.

441—92.11(249A,249J) Reapplication. A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) *Reapplication at least three days before end of certification period.* When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3)*"a"* or *"b"* applies.

92.11(2) *Reapplication within three days of end of certification period or later.* When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) Terminating eligibility. IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.
2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).
3. The member does not pay premiums as required by 441—92.7(249A,249J).
4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).
5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.
6. The member dies.

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member and any unpaid premiums in accordance with 441—76.12(249A). For this purpose, unpaid premiums shall be treated as medical assistance incorrectly paid due to client error.

92.13(1) The department shall recover Medicaid funds expended on behalf of a member and any unpaid premiums from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[**ARC 9135B**, IAB 10/6/10, effective 10/1/10]

441—92.14(249A,249J) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) *Suspension of enrollment.* To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) *Enrollment for limited services.* Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

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CHAPTER 4
CONTESTED CASES AND OTHER PROCEEDINGS

[Prior to 11/19/86, Racing Commission[693]]
[Prior to 11/18/87, Racing and Gaming Division[195]]

491—4.1(17A) Scope and applicability. This chapter applies to contested case proceedings conducted by the racing and gaming commission. The chapter shall also apply to gaming boards' and board of stewards' proceedings and gaming representatives' actions.

491—4.2(17A) Definitions. Except where otherwise specifically defined by law:

"Board of stewards" means a board established by the administrator to review conduct by occupational and pari-mutuel licensees that may constitute violations of the rules and statutes relating to pari-mutuel racing. The administrator may serve as a board of one.

"Commission" means the racing and gaming commission.

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under 1998 Iowa Acts, chapter 1202, section 14.

"Gaming board" means a board established by the administrator to review conduct by occupational, excursion gambling boat, gambling structure, and gambling game licensees that may constitute violations of the rules and statutes relating to gaming. The administrator may serve as a board of one.

"Gaming representative" means an employee of the commission assigned by the administrator to a licensed pari-mutuel racetrack, excursion gambling boat, or gambling structure to perform the supervisory and regulatory duties of the commission.

"Issuance" means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

"Party" means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

"Presiding officer" means the administrative law judge presiding over a contested case hearing or the commission in cases heard by the commission.

"Proposed decision" means the administrative law judge's recommended findings of fact, conclusions of law, decision, and order in a contested case in which the commission did not preside.

"Steward" means a racing official appointed or approved by the commission to perform the supervisory and regulatory duties relating to pari-mutuel racing.

491—4.3(17A) Time requirements.

4.3(1) In computing any period of time prescribed or allowed by these rules or by an applicable statute, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. Legal holidays are prescribed in Iowa Code section 4.1(34).

4.3(2) All documents or papers required to be filed with the commission shall be delivered to any commission office within such time limits as prescribed by law or by rules or orders of the commission. No papers shall be considered filed until actually received by the commission.

4.3(3) For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

DIVISION I
GAMING REPRESENTATIVE, GAMING BOARD, AND BOARD OF STEWARDS

491—4.4(99D,99F) Gaming representatives—licensing and regulatory duties.

4.4(1) The gaming representative shall make decisions whether to approve applications for occupational licenses, in accordance with the rules and statutes.

a. Each decision denying a license for an occupational license shall be in writing. The decision must contain a brief explanation of the reason for the decision, including a reference to the statute or rule serving as the basis for the decision.

b. Rescinded IAB 2/5/03, effective 3/12/03.

c. Rescinded IAB 9/29/04, effective 11/3/04.

d. Upon the filing of a timely and perfected appeal, the applicant has the right to a contested case proceeding, as set forth supra in these rules.

4.4(2) The gaming representative shall monitor, supervise, and regulate the activities of occupational, pari-mutuel racetrack, gambling game, excursion gambling boat, and gambling structure licensees. A gaming representative may investigate any questionable conduct by a licensee for any violation of the rules or statutes. A gaming representative may refer an investigation to the gaming board upon suspicion that a licensee or nonlicensee has committed a violation of the rules or statutes.

a. A gaming representative shall make a referral to the gaming board in writing. The referral shall make reference to rules or statutory provisions at issue and provide a factual basis supporting the violation.

b. The gaming representative making the referral to the gaming board, or a designee of the gaming board, shall appear before the gaming board at the hearing to provide any information requested by the board.

4.4(3) A gaming representative shall summarily suspend an occupational license when a licensee has been formally arrested or charged with a crime that would disqualify the licensee, if convicted, from holding a license and the gaming representative determines that the licensee poses an immediate danger to the public health, safety, or welfare of the patrons, participants, or animals associated with a facility licensed under Iowa Code chapter 99D or 99F. Upon proof of resolution of a disqualifying criminal charge or formal arrest, regardless of summary suspension of a license, the gaming representative shall take one of the following courses of action:

a. If the license was summarily suspended and the charges are dismissed or the licensee is acquitted of the charges, the gaming representative shall reinstate the license.

b. If the licensee is convicted of the charges, the gaming representative shall deny the license.

c. If the licensee is convicted of a lesser charge, it is at the discretion of the gaming representative whether to reinstate or deny the license pursuant to 491—Chapter 6.

4.4(4) The gaming representative shall revoke the license of a person reported to the commission as having refused drug testing or as having a confirmed positive drug test result for a controlled substance, for a drug test conducted pursuant to Iowa Code section 730.5 or 99F.4(20).

4.4(5) A gaming representative may eject and exclude any person from the premises of a pari-mutuel racetrack, excursion gambling boat, or gambling structure for any reason justified by the rules or statutes. The gaming representative may provide notice of ejection or exclusion orally or in writing. The gaming representative may define the scope of the exclusion to any degree necessary to protect the integrity of racing and gaming in Iowa. The gaming representative may exclude the person for a certain or an indefinite period of time.

4.4(6) The gaming representative may forbid any person from continuing to engage in an activity the representative feels is detrimental to racing or gaming until resolved.

4.4(7) The gaming representative shall have other powers and duties set forth in the statutes and rules, and as assigned by the administrator.

4.4(8) A gaming representative may summarily suspend an occupational licensee in accordance with rule 491—4.47(17A).

[**ARC 8029B**, IAB 8/12/09, effective 9/16/09]

491—4.5(99D,99F) Gaming board—duties. The gaming board conducts informal hearings whenever the board has reasonable cause to believe that a licensee, an occupational licensee, or other persons have committed an act or engaged in conduct which is in violation of statute or commission rules. The hearings precede a contested case hearing and are investigative in nature. The following procedures will apply:

4.5(1) The gaming board shall consist of three gaming representatives, as assigned by the administrator. The administrator has the discretion to create more than one gaming board, to set terms for gaming board members, to assign alternates, and to make any decisions necessary for the efficient and effective operation of the gaming board. A gaming representative who has made a referral to the gaming board shall not sit on the board that makes a decision on the referral.

4.5(2) The administrator may designate an employee to act as gaming board coordinator. The gaming board coordinator shall have the power to assist and advise the gaming board through all aspects of the gaming board hearing process. The gaming board coordinator may review any referral from gaming representatives prior to setting the matter for hearing before the gaming board. The gaming board coordinator, in consultation with the administrator or the administrator's designee, may return the referral to the initiating gaming representative if the information provided appears insufficient to establish a violation. The gaming board coordinator shall otherwise assist the gaming board in setting the matter for hearing.

4.5(3) The gaming board, upon receipt of a referral, may review the referral prior to the hearing. The gaming board may return a referral to the initiating gaming representative on its own motion prior to hearing if the information provided appears insufficient to establish a violation.

4.5(4) Upon finding of reasonable cause, the board shall schedule a hearing to which the license holder shall be summoned for the purpose of investigating suspected or alleged misconduct by the license holder, at which all board members or their appointed representatives shall be present in person or by teleconference. The license holder may request a continuance for good cause in writing not less than 24 hours prior to the hearing except in cases of unanticipated emergencies. The continuance need not necessarily stay any intermediate sanctions.

4.5(5) The notice of hearing given to the license holder shall give adequate notice of the time, place and purpose of the board's hearing and shall specify by number the statutes or rules allegedly violated. If a license holder, after receiving adequate notice of a board meeting, fails to appear as summoned, the license holder will be deemed to have waived any right to appear and present evidence to the board.

4.5(6) The gaming board has complete and total authority to decide all issues concerning the process of the hearing. The gaming board shall recognize witnesses and either question the witnesses or allow them to give a narrative account of the facts relevant to the case. The gaming board has the right to request witnesses or additional documents that have not been submitted by the initiating gaming representative. The licensee has no right to present testimony, cross-examine witnesses, make objections, or present argument, unless specifically authorized by the gaming board.

4.5(7) It is the duty and obligation of every licensee to make full disclosure at a hearing before the board of any knowledge possessed regarding the violation of any rule, regulation or law concerning racing and gaming in Iowa. No person may refuse to testify before the board at any hearing on any relevant matter within the authority of the board, except in the proper exercise of a legal privilege. No person shall falsely testify before the board.

4.5(8) Persons who are not holders of a license or occupational license and who have allegedly violated commission rules or statute, or whose presence at a track or on a riverboat is allegedly undesirable, are subject to the authority of the board and to any penalties, as set forth in rule 491—4.7(99D,99F).

4.5(9) The gaming board has the power to interpret the rules and to decide all questions not specifically covered by them. The board has the power to determine all questions arising with reference to the conduct of gaming, and the authority to decide any question or dispute relating to racing or gaming in compliance with rules promulgated by the commission or policies approved for licensees, and persons participating in licensed racing or gaming agree in so doing to recognize and accept that authority. The board may also suspend the license of any license holder when the board has reasonable cause to believe that a violation of law or rule has been committed and that the continued performance of that individual in a licensed capacity would be injurious to the best interests of racing or gaming.

4.5(10) The gaming board shall enter a written decision after each hearing. The decision shall find whether there is a violation of the rules or statutes and, if so, shall briefly set forth the legal and factual

basis for the finding. The decision shall also establish a penalty for any violation. The gaming board has the authority to impose any penalty as set forth in these rules.

4.5(11) Rescinded IAB 9/29/04, effective 11/3/04.

4.5(12) Upon the filing of a timely and perfected appeal, the licensee has the right to a contested case proceeding, as set forth supra in these rules.

4.5(13) Informal settlements. A licensee may enter into a written stipulation representing an informed mutual consent with a gaming representative. This stipulation must specifically outline the violation and the penalty imposed. Stipulations must be approved by the gaming board. Stipulations are considered final agency action and cannot be appealed.

491—4.6(99D,99F) Stewards—licensing and regulatory duties.

4.6(1) The stewards shall make decisions whether to approve applications for occupational licenses, in accordance with the rules and statutes.

a. Each decision denying an application for an occupational license shall be in writing. The decision must contain a brief explanation of the reason for the decision, including a reference to the statute or rule serving as the basis for the decision.

b. Rescinded IAB 2/5/03, effective 3/12/03.

c. An applicant for an occupational license may appeal a decision denying the application. An appeal must be made in writing to the office of the stewards or the commission's office in Des Moines. The appeal must be received within 72 hours of service of the decision. The appeal must contain numbered paragraphs and set forth the name of the person seeking review, the decision to be reviewed, separate assignments of error, clear and concise statement of relevant facts, reference to applicable statutes, rules or other authority, prayer setting forth relief sought and signature, name, address, and telephone number of the person seeking review or that person's representative, or shall be on a form prescribed by the commission.

d. Upon the filing of a timely and perfected appeal, the applicant has the right to a contested case proceeding, as set forth supra in these rules.

4.6(2) The stewards shall monitor, supervise, and regulate the activities of occupational and pari-mutuel racetrack licensees. A steward may investigate any questionable conduct by a licensee for any violation of the rules or statutes. Any steward may refer an investigation to the board of stewards upon suspicion that a licensee or nonlicensee has committed a violation of the rules or statutes.

4.6(3) A steward shall summarily suspend an occupational license when a licensee has been formally arrested or charged with a crime that would disqualify the licensee, if convicted, from holding a license and the steward determines that the licensee poses an immediate danger to the public health, safety, or welfare of the patrons, participants, or animals associated with a facility licensed under Iowa Code chapter 99D or 99F. Upon proof of resolution of a disqualifying criminal charge or formal arrest, regardless of summary suspension of a license, the stewards shall take one of the following courses of action:

a. If the license was summarily suspended and the charges are dismissed or the licensee is acquitted of the charges, the stewards shall reinstate the license.

b. If the licensee is convicted of the charges, the stewards shall deny the license.

c. If the licensee is convicted of a lesser charge, it is at the discretion of the stewards whether to reinstate or deny the license pursuant to 491—Chapter 6.

4.6(4) The stewards may summarily suspend an occupational license in accordance with rule 491—4.47(17A).

4.6(5) Hearings before the board of stewards intended to implement Iowa Code section 99D.7(13) shall be conducted under the following parameters:

a. Upon finding of reasonable cause, the board shall schedule a hearing to which the license holder shall be summoned for the purpose of investigating suspected or alleged misconduct by the license holder. The license holder may request a continuance in writing for good cause not less than 24 hours prior to the hearing except in cases of unanticipated emergencies. The continuance need not necessarily stay any intermediate sanctions.

b. The notice of hearing given to the license holder shall give adequate notice of the time, place and purpose of the board's hearing and shall specify by number the statutes or rules allegedly violated. If a license holder, after receiving adequate notice of a board meeting, fails to appear as summoned, the license holder will be deemed to have waived any right to appear and present evidence to the board.

c. The board has complete and total authority to decide the process of the hearing. The administrator may designate an employee to assist and advise the board of stewards through all aspects of the hearing process. The board shall recognize witnesses and either question the witnesses or allow them to give a narrative account of the facts relevant to the case. The board may request additional documents or witnesses before making a decision. The licensee has no right to present testimony, cross-examine witnesses, make objections, or present argument, unless specifically authorized by the board.

d. It is the duty and obligation of every licensee to make full disclosure at a hearing before the board of any knowledge possessed regarding the violation of any rule, regulation or law concerning racing and gaming in Iowa. No person may refuse to testify before the board at any hearing on any relevant matter within the authority of the board, except in the proper exercise of a legal privilege. No person shall falsely testify before the board.

e. Persons who are not holders of a license or occupational license and who have allegedly violated commission rules or statute, or whose presence at a track is allegedly undesirable, are subject to the authority of the board and to any penalties, as set forth in rule 491—4.7(99D,99F).

f. The board of stewards has the power to interpret the rules and to decide all questions not specifically covered by them. The board of stewards has the power to determine all questions arising with reference to the conduct of racing, and the authority to decide any question or dispute relating to racing in compliance with rules promulgated by the commission or policies approved for licensees, and persons participating in licensed racing or gaming agree in so doing to recognize and accept that authority. The board may also suspend the license of any license holder when the board has reasonable cause to believe that a violation of law or rule has been committed and that the continued performance of that individual in a licensed capacity would be injurious to the best interests of racing or gaming.

g. The board of stewards shall enter a written decision after each hearing. The decision shall state whether there is a violation of the rules or statutes and, if so, shall briefly set forth the legal and factual basis for the finding. The decision shall also establish a penalty for any violation. The board of stewards has the authority to impose any penalty, as set forth in these rules.

h. Rescinded IAB 9/29/04, effective 11/3/04.

i. Upon the filing of a timely and perfected appeal, the licensee has the right to a contested case proceeding, as set forth supra in these rules.

4.6(6) A steward may eject and exclude any person from the premises of a pari-mutuel racetrack, excursion gambling boat, or gambling structure for any reason justified by the rules or statutes. The steward may provide notice of ejection or exclusion orally or in writing. The steward may define the scope of the exclusion to any degree necessary to protect the integrity of racing and gaming in Iowa. The steward may exclude the person for a certain or indefinite period of time.

4.6(7) The stewards shall have other powers and duties set forth in the statutes and rules, and as assigned by the administrator.

4.6(8) Informal settlements. A licensee may enter into a written stipulation representing an informed mutual consent with the stewards. This stipulation must specifically outline the violation and the penalty imposed. Stipulations must be approved by the board of stewards. Stipulations are considered final agency action and cannot be appealed.

[**ARC 8029B**, IAB 8/12/09, effective 9/16/09]

491—4.7(99D,99F) Penalties (gaming board and board of stewards). All penalties imposed will be promptly reported to the commission and facility in writing. The board may impose one or more of the following penalties: eject and exclude an individual from a facility; revoke a license; suspend a license for up to 365 days from the date of the original suspension; place a license on probation; deny a license; impose a fine of up to $1000; or order a redistribution of a racing purse or the payment of or the

withholding of a gaming payout. The board may set the dates for which the suspension must be served. The board may also suspend the license of any person currently under suspension or in bad standing in any other state or jurisdiction by a state racing or gaming commission. If the punishment so imposed is not sufficient, in the opinion of the board, the board shall so report to the commission.

4.7(1) Fines shall be paid within ten calendar days of receipt of the ruling, by the end of business hours, at any commission office. Nonpayment or late payment of a fine may result in an immediate license suspension. All fines are to be paid by the individual assessed the fine.

4.7(2) If the fine is appealed to the board, the appeals process will not stay the fine. The fine will be due as defined in subrule 4.7(1).

4.7(3) If the party is successful in the appeal, the amount of the fine will be refunded to the party as soon as possible after the date the decision is rendered.

4.7(4) Refunds due under subrule 4.7(3) will be mailed to the party's current address on record.

4.7(5) When a racing animal or the holder of an occupational license is suspended by the board at one location, the suspension shall immediately become effective at all other facilities under the jurisdiction of the commission.

[**ARC 9987B**, IAB 2/8/12, effective 3/14/12]

491—4.8(99D,99F) Effect of another jurisdiction's order. The commission or board may take appropriate action against a license holder or other person who has been excluded from a track or gaming establishment in another jurisdiction to exclude that person from any track or gaming establishment under the commission's jurisdiction. Proceedings shall be conducted in the same manner as prescribed by these rules for determining misconduct on Iowa tracks or in gaming establishments and shall be subject to the same appeal procedures.

The commission and stewards shall have discretion to honor rulings from other jurisdictions regarding license suspension or revocation or the eligibility of contestants. Whenever the commission decides to honor an order from another jurisdiction, the commission representatives shall schedule a hearing at which the licensee shall be required to show cause as to why the license should not be suspended or revoked.

491—4.9(99D,99F) Service of administrative actions. Any administrative action taken against an applicant or occupational licensee shall be served on the applicant or occupational licensee by personal service or by certified mail with return receipt requested to the last-known address on the application.

4.9(1) If the applicant or licensee is represented by legal counsel, a copy of the written decision shall also be provided to legal counsel by regular mail. However, the applicant or licensee must still be served in accordance with this rule.

4.9(2) If the administrative action involves an alleged medication violation that could result in disqualification of a contestant, the stewards shall provide by regular mail notice of the hearing and all subsequent rulings to the owner of the contestant.

491—4.10(99D,99F) Appeals of administrative actions. A license applicant or an occupational licensee may appeal a denial, suspension or ruling. An appeal must be made in writing to the office of the gaming representative or the commission office in Des Moines. The appeal must be received within 72 hours of service of the decision and is not considered filed until received by the commission. The appeal must contain numbered paragraphs and set forth the name of the person seeking review; the decision to be reviewed; separate assignments of error; clear and concise statement of relevant facts; reference to applicable statutes, rules or other authority; prayer setting forth relief sought; and signature, name, address, and telephone number of the person seeking review or that person's representative; or shall be on a form prescribed by the commission. If a licensee is granted a stay of a suspension pursuant to 491—4.45(17A) and the ruling is upheld in a contested case proceeding, the board of stewards may reassign the dates of suspension so that the suspension dates are served in the state of Iowa.

491—4.11 to **4.19** Reserved.

DIVISION II
CONTESTED CASES

491—4.20(17A) Requests for contested case proceedings not covered in Division I. Any person or entity claiming an entitlement to a contested case proceeding, which is not otherwise covered by the procedures set forth in Division I, shall file a written request for such a proceeding within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the commission action in question.

The request for a contested case proceeding should state the name and address of the requester, identify the specific commission action which is disputed and, if the requester is represented by a lawyer, identify the provisions of law or precedent requiring or authorizing the holding of a contested case proceeding in the particular circumstances involved, and include a short and plain statement of the issues of material fact in dispute.

491—4.21(17A) Notice of hearing.

4.21(1) *Delivery.* Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery may be executed by:

a. Personal service as provided in the Iowa Rules of Civil Procedure; or

b. Certified mail, return receipt requested; or

c. First-class mail; or

d. Publication, as provided in the Iowa Rules of Civil Procedure.

4.21(2) *Contents.* The notice of hearing shall contain the following information:

a. A statement of the time, place, and nature of the hearing;

b. A statement of the legal authority and jurisdiction under which the hearing is to be held;

c. A reference to the particular sections of the statutes and rules involved;

d. A short and plain statement of the matters asserted. If the commission or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application, a more definite and detailed statement shall be furnished;

e. Identification of all parties including the name, address and telephone number of the person who will act as advocate for the commission or the state and of parties' counsel where known;

f. Reference to the procedural rules governing conduct of the contested case proceeding;

g. Reference to the procedural rules governing informal settlement;

h. Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer (e.g., agency head, members of multimembered agency head, administrative law judge from the department of inspections and appeals); and

i. Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11(1)*"a"* and rule 491—4.22(17A), that the presiding officer be an administrative law judge.

491—4.22(17A) Presiding officer. Contested case hearings may be heard directly by the commission. The commission, or the administrator, shall decide whether it will hear the appeal or whether the appeal will be heard by an administrative law judge who shall serve as the presiding officer. When the appeal is heard by an administrative law judge, the administrative law judge is authorized to issue a proposed decision.

4.22(1) Any party who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must file a written request within 20 days after service of a notice of hearing which identifies or describes the presiding officer as the commission chair, members of the commission or commission employees.

4.22(2) The administrator may deny the request only upon a finding that one or more of the following apply:

a. Neither the administrator nor any officer of the commission under whose authority the contested case is to take place is a named party to the proceeding or a real party in interest to that proceeding.

b. There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.

c. The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.

d. The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.

e. Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.

f. The request was not timely filed.

g. The request is not consistent with a specified statute.

4.22(3) The administrator shall issue a written ruling specifying the grounds for the decision within 20 days after a request for an administrative law judge is filed.

4.22(4) An administrative law judge assigned to act as presiding officer in a contested case shall have a Juris Doctorate degree unless waived by the agency.

4.22(5) Except as provided otherwise by rules 491—4.41(17A) and 491—4.42(17A), all rulings by an administrative law judge acting as presiding officer are subject to appeal to the commission. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

4.22(6) Unless otherwise provided by law, the commission, when reviewing a proposed decision upon intra-agency appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

491—4.23(17A) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the commission in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

491—4.24(17A) Telephone proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen.

491—4.25(17A) Disqualification.

4.25(1) A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

a. Has a personal bias or prejudice concerning a party or a representative of a party;

b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship that:

(1) Is a party to the case, or an officer, director or trustee of a party;

(2) Is a lawyer in the case;

(3) Is known to have an interest that could be substantially affected by the outcome of the case; or

(4) Is likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

4.25(2) The term "personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other commission functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and subrules 4.25(3) and 4.39(9).

4.25(3) In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

4.25(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 4.25(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 491—4.41(17A) and seek a stay under rule 491—4.45(17A).

491—4.26(17A) Consolidation—severance.

4.26(1) *Consolidation.* The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

4.26(2) *Severance.* The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

491—4.27(17A) Pleadings.

4.27(1) Pleadings, other than the notice of appeal, will not be required in appeals from a licensing decision by a gaming representative, gaming board, or board of stewards. However, pleadings may be required in other contested cases or as ordered by the presiding officer.

4.27(2) Petition.

a. Any petition required in a contested case proceeding shall be filed within 20 days of delivery of the notice of hearing or subsequent order of the presiding officer, unless otherwise ordered.

b. A petition shall state in separately numbered paragraphs the following:

(1) The persons or entities on whose behalf the petition is filed;

(2) The particular provisions of statutes and rules involved;

(3) The relief demanded and the facts and law relied upon for such relief; and

(4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

4.27(3) Answer. An answer shall be filed within 20 days of service of the petition unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement when appropriate.

An answer shall show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer that could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

4.27(4) Amendment. Any notice of appeal, notice of hearing, petition, or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

491—4.28(17A) Service and filing of pleadings and other papers.

4.28(1) *When service required.* Except where otherwise provided by law, every pleading, motion, document, or other paper filed in a contested case proceeding and every paper relating to discovery in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the state or the commission, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

4.28(2) *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

4.28(3) *Filing—when required.* After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with the commission at 717 East Court, Suite B, Des Moines, Iowa 50309. All pleadings, motions, documents or other papers that are required to be served upon a party shall be filed simultaneously with the commission.

4.28(4) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the commission office at 717 East Court, Suite B, Des Moines, Iowa 50309, delivered to an established courier service for immediate delivery to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

4.28(5) *Proof of mailing.* Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the (agency office and address) and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).

(Date) (Signature)

491—4.29(17A) Discovery.

4.29(1) Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

4.29(2) Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule 4.29(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

4.29(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

491—4.30(17A) Subpoenas.

4.30(1) *Issuance.*

a. A commission subpoena shall be issued to a party on request. Such a request must be in writing. In the absence of good cause for permitting later action, a request for a subpoena must be received at least three days before the scheduled hearing. The request shall include the name, address, and telephone number of the requesting party.

b. Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

4.30(2) *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

491—4.31(17A) Motions.

4.31(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

4.31(2) Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the commission or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

4.31(3) The presiding officer may schedule oral argument on any motion.

4.31(4) Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the commission or an order of the presiding officer.

4.31(5) Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment must be filed and served at least 45 days prior to the scheduled hearing date, or other time period determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 15 days, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not less than 20 days after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to rule 491—4.44(17A) and appeal pursuant to rule 491—4.43(17A).

491—4.32(17A) Prehearing conference.

4.32(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the commission to all parties. For good cause the presiding officer may permit variances from this rule.

4.32(2) Each party shall bring to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names.

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

4.32(3) In addition to the requirements of subrule 4.32(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters that the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters that will expedite the hearing.

4.32(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

491—4.33(17A) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

4.33(1) A written application for a continuance shall:

a. Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or the party's representative.

An oral application for a continuance may be made if the presiding officer waives the requirement for a written motion. However, a party making such an oral application for a continuance must confirm that request by written application within five days after the oral request unless that requirement is waived by the presiding officer. No application for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The commission may waive notice of such requests for a particular case or an entire class of cases.

4.33(2) In determining whether to grant a continuance, the presiding officer may consider:

a. Prior continuances;

b. The interests of all parties;

c. The likelihood of informal settlement;

d. The existence of an emergency;

e. Any objection;

f. Any applicable time requirements;

g. The existence of a conflict in the schedules of counsel, parties, or witnesses;

h. The timeliness of the request; and

i. Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.

491—4.34(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing only in accordance with commission rules. Unless otherwise provided, a withdrawal shall be with prejudice.

491—4.35(17A) Intervention.

4.35(1) *Motion.* A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

4.35(2) *When filed.* Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

4.35(3) *Grounds for intervention.* The movant shall demonstrate that (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties.

4.35(4) *Effect of intervention.* If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

491—4.36(17A) Hearing procedures.

4.36(1) The presiding officer presides at the hearing, and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

4.36(2) All objections shall be timely made and stated on the record.

4.36(3) Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations, or associations may be represented by any member, officer, director, or duly authorized agent. Any party may be represented by an attorney or another person authorized by law.

4.36(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

4.36(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

4.36(6) Witnesses may be sequestered during the hearing.

4.36(7) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

491—4.37(17A) Evidence.

4.37(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

4.37(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

4.37(3) Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

4.37(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

4.37(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

4.37(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

491—4.38(17A) Default.

4.38(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

4.38(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

4.38(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final commission action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 491—4.43(17A). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

4.38(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

4.38(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

4.38(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

4.38(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 491—4.41(17A).

4.38(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

4.38(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues (but, unless the defaulting party has appeared, it cannot exceed the relief demanded).

4.38(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 491—4.45(17A).

491—4.39(17A) Ex parte communication.

4.39(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative

of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the commission or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 4.25(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

4.39(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

4.39(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

4.39(4) To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communication shall be provided in compliance with rule 491—4.28(17A) and may be supplemented by telephone, facsimile, E-mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

4.39(5) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

4.39(6) The administrator or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under subrule 4.25(1) or other law and they comply with subrule 4.39(1).

4.39(7) Communications with the presiding officer involving scheduling or procedural matters uncontested do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 491—4.33(17A).

4.39(8) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order (or disclosed). If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

4.39(9) Promptly after being assigned to serve as presiding officer on a hearing panel, as a member of a full board hearing, on an intra-agency appeal, or other basis, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

4.39(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension, or revocation of the privilege to practice before the commission. Violation of ex parte communication prohibitions by commission personnel shall be reported to the administrator for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

491—4.40(17A) Recording costs. Upon request, the commission shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

491—4.41(17A) Interlocutory appeals. Upon written request of a party or on its own motion, the commission may review an interlocutory order of the presiding officer. In determining whether to do so, the commission shall weigh the extent to which its granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the commission at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

491—4.42(17A) Final decision.

4.42(1) When the commission presides over the reception of evidence at the hearing, its decision is a final decision.

4.42(2) When the commission does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the commission without further proceedings unless there is an appeal to, or review on motion of, the commission within the time provided in rule 491—4.43(17A).

4.42(3) The commission has the authority to deny, suspend, or revoke any license applied for or issued by the commission or to fine a licensee or a holder of an occupational license.

491—4.43(17A) Appeals and review.

4.43(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the commission within 10 days after issuance of the proposed decision.

4.43(2) *Review.* The commission may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

4.43(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the commission. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

a. The parties initiating the appeal;

b. The proposed decision or order appealed from;

c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

d. The relief sought;

e. The grounds for relief.

4.43(4) *Requests to present additional evidence.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The commission may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

4.43(5) *Scheduling.* The commission shall issue a schedule for consideration of the appeal.

4.43(6) *Briefs and arguments.* Unless otherwise ordered, briefs, if any, must be filed within five days of meeting.

491—4.44(17A) Applications for rehearing.

4.44(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

4.44(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the agency decision on the existing record and whether, on the basis of the grounds enumerated in subrule 4.43(4), the applicant requests an opportunity to submit additional evidence.

4.44(3) *Time of filing.* The application shall be filed with the commission within 20 days after issuance of the final decision.

4.44(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the commission shall serve copies on all parties.

4.44(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the commission grants the application within 20 days after its filing.

491—4.45(17A) Stays of commission actions.

4.45(1) *When available.*

a. Any party to a contested case proceeding may petition the commission for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the commission. The petition for a stay shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The administrator may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the commission for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition for a stay shall state the reasons justifying a stay or other temporary remedy.

4.45(2) *When granted.* In determining whether to grant a stay, the presiding officer or administrator shall consider the factors listed in Iowa Code section 17A.19(5).

4.45(3) *Vacation.* A stay may be vacated by the issuing authority upon application by the commission or any other party. When a stay has been vacated, the commission or the commission's designee shall implement the original order or sanction which had been stayed. The commission or the commission's designee shall have full authority to determine how the original order or sanction is to be implemented.

491—4.46(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

491—4.47(17A) Emergency adjudicative proceedings.

4.47(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, the commission, gaming representatives, or stewards may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the commission by emergency adjudicative order. Before the issuing of an emergency adjudicative order the commission shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the commission is proceeding on the basis of reliable information;

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

e. Whether the specific action contemplated by the commission is necessary to avoid the immediate danger.

4.47(2) *Issuance.*

a. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

(1) Personal delivery;

(2) Certified mail, return receipt requested, to the last address on file with the commission;

(3) Certified mail to the last address on file with the commission;

(4) First-class mail to the last address on file with the commission; or

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that commission orders be sent by fax and has provided a fax number for that purpose.

b. To the degree practicable, the commission shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

4.47(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the commission shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

4.47(4) *Completion of proceedings.* Issuance of a written emergency adjudicative order shall include notification of the date on which commission proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further commission proceedings to a later date will be granted only in compelling circumstances upon application in writing.

491—4.48(17A) Contested case hearings before the commission. The commission may initiate a hearing upon its own motion, pursuant to any matter within its jurisdiction.

These rules are intended to implement Iowa Code chapters 17A, 99D and 99F.

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◊ Two or more ARCs

CHAPTER 8
WAGERING AND SIMULCASTING

[Prior to 11/19/86, Racing Commission[693]]
[Prior to 11/18/87, Racing and Gaming Division[195]]

491—8.1(99D) Definitions.

"Administrator" means the administrator or administrator's designee of the Iowa racing and gaming commission.

"Association" means anyone conducting a licensed meet in Iowa.

"Authorized receiver" means a receiver that conducts and operates a pari-mutuel wagering system on the results of contests being held or conducted and simulcast from the enclosures of one or more host associations.

"Betting interest" means a number assigned to a single runner, an entry or a field for wagering purposes.

"Board" means the board of judges or the board of stewards.

"Breakage" means the odd cents by which the amount payable on each dollar wagered in a pari-mutuel pool exceeds a multiple of ten cents. "Breakage" is the net pool minus payoff.

"Commission" means the Iowa racing and gaming commission.

"Commission representative" means an employee of the commission designated to represent them in matters pertaining to the operation of the mutuel department. In the absence of a specifically appointed representative, a commission steward will perform the functions and duties of the commission representative.

"Contest" means a race on which wagers are placed.

"Dead heat" means that two or more runners have tied at the finish line for the same position in the order of finish.

"Double" means a wager to select the winners of two consecutive races and is not a parlay and has no connection with or relation to any other pool conducted by the association and shall not be construed as a "quinella double."

"Entry" means two or more runners are coupled in a contest because of common ties and a wager on one of them shall be a wager on all of them.

"Exacta" (may also be known as "perfecta" or "correcta") means a wager selecting the exact order of finish for first and second in that contest and is not a parlay and has no connection with or relation to any other pool conducted by the association.

"Field" is when the individual runners competing in a contest exceed the numbering capacity of the totalizator and all runners of the higher number shall be grouped together. A wager on one in the field shall be a wager on all. (No "fields" shall be allowed in greyhound racing.)

"Guest association" means an association which offers licensed pari-mutuel wagering on contests conducted by another association (the host) in either the same state or another jurisdiction.

"Host association" means the association conducting a licensed pari-mutuel meeting from which authorized contests or entire performances are simulcast.

"Interstate simulcasting" means the telecast of live audio and visual signals of pari-mutuel racing sent to or received from a state outside the state of Iowa to an authorized racing or gaming facility for the purpose of wagering.

"Intrastate simulcasting" means the telecast of live audio and visual signals of pari-mutuel racing conducted on a licensed pari-mutuel track within Iowa sent to or received from an authorized pari-mutuel facility within Iowa for the purpose of pari-mutuel wagering.

"Law" or *"laws"* means the Iowa Code.

"Minus pool" is when the total amount of money to be returned to the public exceeds what is in the pool because of commission being deducted and the rule stipulation that no mutuel tickets shall be paid at less than $1.10 for each $1.00 wagered.

"Mutuel department" means that area of a racetrack where wagers are made and winning tickets are cashed; where the totalizator is installed and any area used directly in the operation of pari-mutuel wagering.

"Mutuel manager" means an employee of the association who manages the mutuel department.

"Net pool" means the amount remaining in each separate pari-mutuel pool after the takeout percentage, as provided for by Iowa Code section 99D.11, has been deducted.

"No contest" means that a specific race has been declared "no contest" by the stewards in accordance with the pari-mutuel rules and rules of racing for that breed and that certain pools shall be refunded.

"Odds" means the approximate payoffs per dollar based on win pool wagering only on each betting interest for finishing first without a dead heat with another betting interest.

"Official" means that the order of finish for the race is "official" and that payoff prices based upon the "official" order of finish shall be posted.

"Order of finish" means the finishing order of each runner from first place to last place in each race. For horse racing only, the order of finish may be changed by the stewards for a rule infraction prior to posting the "official order of finish."

"Overpayment" is when the payoff to the public resulting from errors in calculating pools and errors occurring in the communication of payoffs results in more money returned to the public than is actually due.

"Pari-mutuel output data" means the data provided by the totalizator other than sales transaction data including, but not limited to, the odds, will pays, race results, and payoff prices.

"Pari-mutuel pool" means the total amount wagered on each separate pari-mutuel pool for payoff purposes.

"Payoff" means the amount distributed to holders of valid winning pari-mutuel tickets in each pool as determined by the official order of finish and includes the amount wagered and profit.

"Pick (n)" means a betting transaction in which a purchaser selects winner(s) of (x) number of contests designated by the association during one racing card.

"Pick three" means a wager to select the winners of three consecutive races and is not a parlay and has no connection with or relation to any other pool conducted by the association.

"Place" means a runner finishing second.

"Place pick (n) pools" means a wager to select the first- or second-place finisher in each of a designated number of contests.

"Place pool" means the total amount of money wagered on all betting interests in each race to finish first or second.

"Post time" is the scheduled starting time for a contest.

"Profit split" is a division of profit among separate winning betting interests or winning betting combinations resulting in two or more payoff prices.

"Quinella" means a wager selecting two runners to finish first and second, regardless of the order of finish, and is not a parlay and has no connection with or relation to any other pool conducted by the association.

"Quinella double" means a wager which consists of selecting the quinella in each of two designated contests and is an entirely separate pool from all other pools and has no connection with or relation to any other pool conducted by the association.

"Runner" means each entrant in a contest, designated by a number as a betting interest.

"Sales transaction data" means the data between totalizator ticket-issuing machines and the totalizator central processing unit for the purpose of accepting wagers and generating, canceling and cashing pari-mutuel tickets and the financial information resulting from processing sales transaction data, such as handle.

"Show" means a runner finishing third.

"Show pool" is the total amount of money wagered on all betting interests in each contest to finish either first, second or third.

"State" means the state of Iowa.

"Stewards" means the board of stewards or board of judges.

"Superfecta" means a wager selecting the exact order of finish for first, second, third, and fourth in that contest and is not a parlay and has no connection with or relation to any other pool conducted by the association.

"Takeout percentage" means the amount authorized by Iowa Code section 99D.11 to be deducted from each separate pari-mutuel pool.

"Totalizator" is a machine for registering wagers, computing odds and payoffs based upon data supplied by each pari-mutuel ticket-issuing machine.

"Tote board" means the board that is used to display to the public the winning approximate odds or approximate payoffs on runner, payoffs, and other pertinent information directly related to a contest.

"Trifecta" means a wager selecting the exact order of finish for first, second, and third in that race and is not a parlay and has no connection with or relation to any other pool conducted by the association.

"Tri-superfecta" means a wager selecting the exact order of finish for first, second and third in the first designated tri-super contest combined with selecting the exact order of finish for first, second, third and fourth in the second designated tri-super contest.

"Twin quinella" means a wager in which the bettor selects the first two finishers, regardless of order, in each of two designated contests. Each winning ticket for the twin quinella must be exchanged for a free ticket on the second twin quinella contest in order to remain eligible for the second-half twin quinella pool.

"Twin superfecta" means a wager in which the bettor selects the first four finishers, in their exact order, in each of two designated contests. Each winning ticket for the first twin superfecta contest must be exchanged for a free ticket on the second twin superfecta contest in order to remain eligible for the second-half twin superfecta pool.

"Twin trifecta" means a wager in which the bettor selects the three runners that will finish first, second, and third in the exact order as officially posted in each of the two designated twin trifecta races.

"Underpayment" is when the payoff to the public resulting from errors in calculating pools and errors occurring in the communication in payoffs results in less money returned to the public than is actually due.

"Win" means a runner finishing first.

"Win pool" means the total amount wagered on all betting interests in each contest to finish first.

491—8.2(99D) General.

8.2(1) *Wagering.* Each association shall conduct wagering in accordance with applicable laws and these rules. Such wagering shall employ a pari-mutuel system approved by the commission. The totalizator shall be tested prior to and during the meeting as required by the commission. All systems of wagering other than pari-mutuel, such as bookmaking and auction-pool selling, are prohibited and any person attempting to participate in prohibited wagering shall be ejected or excluded from association grounds.

8.2(2) *Records.* The association shall maintain records of all wagering so the commission may review such records for any contest including the opening line, subsequent odds fluctuation, the amount and at which window wagers were placed on any betting interest and such other information as may be required. Such wagering records shall be retained by each association and safeguarded for a period of time specified by the commission. The commission may require that certain of these records be made available to the wagering public at the completion of each contest.

The association shall provide the commission with a list of the licensed individuals afforded access to pari-mutuel records and equipment at the wagering facility.

8.2(3) *Pari-mutuel tickets.* A pari-mutuel ticket is evidence of a contribution to the pari-mutuel pool operated by the association and is evidence of the obligation of the association to pay to the holder thereof such portion of the distributable amount of the pari-mutuel pool as is represented by such valid pari-mutuel ticket. The association shall cash all valid winning tickets when such are presented for payment during the course of the meeting where sold, and for a specified period after the last day of the meeting, as provided in paragraph 8.2(4)*"g."*

a. To be deemed a valid pari-mutuel ticket, such ticket shall have been issued by a pari-mutuel ticket machine operated by the association and recorded as a ticket entitled to a share of the pari-mutuel pool, and contain imprinted information as to:

(1) The name of the association operating the meeting.

(2) A unique identifying number or code.

(3) Identification of the terminal at which the ticket was issued.

(4) A designation of the performance for which the wagering transaction was issued.

(5) The contest number for which the pool is conducted.

(6) The type(s) of wagers represented.

(7) The number(s) representing the betting interests for which the wager is recorded.

(8) The amount(s) of the contributions to the pari-mutuel pool or pools for which the ticket is evidence.

b. No pari-mutuel ticket recorded or reported as previously paid, canceled, or nonexistent shall be deemed a valid pari-mutuel ticket by the association. The association may withhold payment and refuse to cash any pari-mutuel ticket deemed not valid, except as provided in paragraph 8.2(4)*"e."*

8.2(4) *Pari-mutuel ticket sales.*

a. Pari-mutuel tickets shall not be sold by anyone other than an association licensed to conduct pari-mutuel wagering.

b. No pari-mutuel ticket may be sold on a contest for which wagering has already been closed and no association shall be responsible for ticket sales entered into but not completed by issuance of a ticket before the totalizator is closed for wagering on such contest.

c. Claims pertaining to a mistake on an issued or unissued ticket must be made by the bettor prior to leaving the seller's window.

d. Payment on winning pari-mutuel wagers shall be made on the basis of the order of finish as purposely posted and declared "official." Any subsequent change in the order of finish or award of purse money(s) as may result from a subsequent ruling by the stewards or administrator shall in no way affect the pari-mutuel payoff. If an error in the posted order of finish or payoff figures is discovered, the official order of finish or payoff prices may be corrected and an announcement concerning the change shall be made to the public.

e. The association shall not satisfy claims on lost, mutilated, or altered pari-mutuel tickets without authorization from the administrator.

f. The association shall have no obligation to enter a wager into a betting pool if unable to do so due to equipment failure.

g. Payment on valid pari-mutuel tickets shall be made only upon presentation and surrender to the association where the wager was made within 60 days following the close of the meet during which the wager was made. Failure to present any such ticket within 60 days shall constitute a waiver of the right to receive payment.

8.2(5) *Advance performance wagering.* No association shall permit wagering to begin more than one hour before scheduled post time of the first contest of a performance unless it has first obtained the authorization of the administrator.

8.2(6) *Claims for payment from pari-mutuel pool.* At a designated location, a written, verified claim for payment from a pari-mutuel pool shall be accepted by the association in any case where the association has withheld payment or has refused to cash a pari-mutuel wager. The claim shall be made on such form as approved by the administrator, and the claimant shall make such claim under penalty of perjury. The original of such claim shall be forwarded to the administrator within 48 hours.

a. In the case of a claim made for payment of a mutilated pari-mutuel ticket which does not contain the total imprinted elements required in paragraph 8.2(3)*"a"* of these general provisions, the association shall make a recommendation to accompany the claim forwarded to the administrator as to whether or not the mutilated ticket has sufficient elements to be positively identified as a winning ticket.

b. In the case of a claim made for payment on a pari-mutuel wager, the administrator shall adjudicate the claim and may order payment thereon from the pari-mutuel pool or by the association, or may deny the claim, or may make such other order as the administrator may deem proper.

8.2(7) *Payment for errors.* If an error occurs in the payment amounts for pari-mutuel wagers which are cashed or entitled to be cashed; and as a result of such error the pari-mutuel pool involved in the error is not correctly distributed among winning ticket holders, the following shall apply:

a. Verification is required to show that the amount of the commission, the amount in breakage, and the amount in payoffs are equal to the total gross pool. If the amount of the pool is more than the amount used to calculate the payoff, the underpayment shall be added to the corresponding pool of the next contest. If an underpayment is discovered after the close of the meeting, the underpayment shall be held in an interest-bearing account approved by the administrator until being added, together with accrued interest, to the corresponding pool of the next meet.

b. Any claim not filed with the association within 30 days, inclusive of the date on which the underpayment was publicly announced, shall be deemed waived; and the association shall have no further liability therefor.

c. In the event the error results in an overpayment to winning wagers, the association shall be responsible for such payment.

8.2(8) *Betting explanation.* A summary explanation of pari-mutuel wagering and each type of betting pool offered shall be published in the program for every wagering performance. The rules of racing relative to each type of pari-mutuel pool offered must be prominently displayed on association grounds and available upon request through association representatives.

8.2(9) *Display of betting information.*

a. Approximate odds for win pool betting shall be posted on display devices within view of the wagering public and updated at intervals of not more than 90 seconds.

b. The probable payoff or amounts wagered, in total and on each betting interest, for other pools may be displayed to the wagering public at intervals and in a manner approved by the administrator.

c. Official results and payoffs must be displayed upon each contest being declared official.

8.2(10) *Canceled contests.* If a contest is canceled or declared "no contest," refunds shall be granted on valid wagers in accordance with these rules.

8.2(11) *Refunds.*

a. Notwithstanding other provisions of these rules, refunds of the entire pool shall be made on:

(1) Win pools, exacta pools, and first-half double pools offered in contests in which the number of betting interests has been reduced to fewer than two.

(2) Place pools, quinella pools, trifecta pools, first-half quinella double pools, first-half twin quinella pools, first-half twin trifecta pools, and first-half tri-superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than three.

(3) Show pools, superfecta pools, and first-half twin superfecta pools offered in contests in which the number of betting interests has been reduced to fewer than four.

b. Authorized refunds shall be paid upon presentation and surrender of the affected pari-mutuel ticket.

8.2(12) *Coupled entries and mutuel fields.*

a. Contestants coupled in wagering as a coupled entry or mutuel field shall be considered part of a single betting interest for the purpose of price calculations and distribution of pools. Should any contestant in a coupled entry or mutuel field be officially withdrawn or scratched, the remaining contestants in that coupled entry or mutuel field shall remain valid betting interests and no refunds will be granted. If all contestants within a coupled entry or mutuel field are scratched, then tickets on such betting interests shall be refunded, notwithstanding other provisions of these rules.

b. For the purpose of price calculations only, coupled entries and mutuel fields shall be calculated as a single finisher, using the finishing position of the leading contestant in that coupled entry or mutuel field to determine order of placing. This rule shall apply to all circumstances, including situations involving a dead heat, except as otherwise provided by these rules.

8.2(13) *Pools dependent upon betting interests.* Unless the administrator otherwise provides, at the time the pools are opened for wagering, the association:

a. May offer win, place, and show wagering on all contests with six or more betting interests.

b. May be allowed to prohibit show wagering on any contest with five or fewer betting interests scheduled to start.

c. May be allowed to prohibit place wagering on any contest with four or fewer betting interests scheduled to start.

d. May be allowed to prohibit quinella wagering on any contest with three or fewer betting interests scheduled to start.

e. May be allowed to prohibit quinella double wagering on any contests with three or fewer betting interests scheduled to start.

f. May be allowed to prohibit exacta wagering on any contest with three or fewer betting interests scheduled to start.

g. Shall prohibit trifecta wagering on any contest with five or fewer betting interests scheduled to start, or as provided in (1) below:

(1) Cancel trifecta. The stewards have the authority to cancel trifecta wagering at any time they determine an irregular pattern of wagering or determine that the conduct of the race would not be in the interest of the regulation of the pari-mutuel wagering industry or in the public confidence in racing. The stewards may approve smaller fields for trifecta wagering if extraneous circumstances are shown by the licensee.

(2) Reserved.

h. May prohibit superfecta wagering on any contest with seven or fewer betting interests scheduled to start.

i. May be allowed to prohibit twin quinella wagering on any contests with three or fewer betting interests scheduled to start.

j. May prohibit twin trifecta wagering on any contests with seven or fewer betting interests scheduled to start, except as provided in 8.2(13)*"g"*(1).

k. May prohibit tri-superfecta wagering on any contests with seven or fewer betting interests scheduled to start.

l. May prohibit twin superfecta wagering on any contests with seven or fewer betting interests scheduled to start.

8.2(14) *Prior approval required for betting pools.*

a. An association that desires to offer new forms of wagering must apply in writing to the administrator and receive written approval prior to implementing the new betting pool.

b. The association may suspend previously approved forms of wagering with the prior approval of the administrator. Any carryover shall be held until the suspended form of wagering is reinstated. An association may request approval of a form of wagering or separate wagering pool for specific requirements.

8.2(15) *Closing of wagering in a contest.*

a. A commission representative shall close wagering for each contest after which time no pari-mutuel tickets shall be sold for that contest. All wagering shall stop and all pari-mutuel machines shall be locked at post time or at the actual start of the races. Machines shall be automatically locked by the stewards, unless unusual circumstances dictate the stewards to act differently.

b. The association shall maintain, in good order, a system approved by the administrator for closing wagering.

8.2(16) *Complaints pertaining to pari-mutuel operations.*

a. When a patron makes a complaint regarding the pari-mutuel department to an association, the association shall immediately issue a complaint report, setting out:

(1) The name of the complainant;

(2) The nature of the complaint;

(3) The name of the persons, if any, against whom the complaint was made;

(4) The date of the complaint;

(5) The action taken or proposed to be taken, if any, by the association.

b. The association shall submit every complaint report to the commission within five days after the complaint was made.

8.2(17) *Licensed employees.* All licensees shall report any known irregularities or wrongdoings by any person involving pari-mutuel wagering immediately to the administrator and cooperate in subsequent investigations.

8.2(18) *Unrestricted access.* The association shall permit the commission unrestricted access at all times to its facilities and equipment and to all books, ledgers, accounts, documents and records of the association that relate to pari-mutuel wagering.

8.2(19) *Totalizator breakdown.* In the event of irreparable breakdown of the totalizator during the wagering on a race, the wagering on that race shall be declared closed and the payoff shall be computed on the sums wagered in each pool up to the time of the breakdown.

8.2(20) *Minimum wager and payoff.* The minimum wager to be accepted by any licensed association for win, place and show wagering shall be $2. The minimum payoff on a $2 wager shall be $2.20. For all other wagers, the minimum wager to be accepted by any licensed association shall be $1. The minimum payoff for a $1 wager shall be $1.10. Any deviation from this must be approved by the administrator. In cases where a minus pool occurs, the association is responsible for the payment of the minimum payoff and no breakage shall be incurred from that pari-mutuel pool.

8.2(21) *Minors prohibited from wagering.* No minor shall be permitted by any licensed association to purchase or cash a pari-mutuel ticket.

8.2(22) *Emergency situations.* In the event of an emergency in connection with the pari-mutuel department not covered in these rules, the pari-mutuel manager representing the association shall report the problem to the stewards and the association and the stewards shall render a full report to the administrator within 48 hours.

8.2(23) *Commission mutuel supervisor.* The commission may employ a mutuel supervisor with accounting experience to serve as the commission's designated representative at each race meeting as provided in Iowa Code section 99D.19. In the absence of a specifically appointed commission mutuel supervisor, the board of stewards or simulcast steward will perform the functions and duties of the commission.

491—8.3(99D) Calculation of payoffs and distribution of pools.

8.3(1) *Pools permitted.* All permitted pari-mutuel wagering pools shall be separately and independently calculated and distributed. The pari-mutuel wagering pools permitted in this state shall be for win, place, show, double, exacta, trifecta, tri-super, twin-trifecta, superfecta, quinella, quinella double, twin quinella, pick (3), and pick (n), place pick (n), each with separate and independent calculation and distribution. Takeout shall be deducted from each gross pool as stipulated by Iowa Code section 99D.11. The remainder of the moneys in the pool shall constitute the net pool for distribution as payoff on winning wagers.

a. For each wagering pool, the amount wagered on the winning betting interest or betting combinations is deducted from the net pool to determine the profit; the profit is then divided by the amount wagered on the winning betting interest or combinations, such quotient being the profit per dollar.

b. Either the standard or net price calculation procedure may be used to calculate single commission pools, while the net price calculation procedure must be used to calculate multicommission pools.

(1) Standard price calculation procedure.

SINGLE PRICE POOL (WIN POOL)

Gross pool	=	sum of wagers on all betting interests – refunds
Takeout	=	gross pool × percent takeout
Net pool	=	gross pool – takeout
Profit	=	net pool – gross amount bet on winner
Profit per dollar	=	profit/gross amount bet on winner
$1 unbroken price	=	profit per dollar + $1
$1 broken price	=	$1 unbroken price rounded down to the break point
Total payout	=	$1 broken price × gross amount bet on winner
Total breakage	=	net pool – total payout

PROFIT SPLIT (PLACE POOL)

Profit is net pool less gross amount bet on all place finishers. Finishers split profit ½ and ½ (place profit), then divide by gross amount bet on each place finisher for two unique prices.

PROFIT SPLIT (SHOW POOL)

Profit is net pool less gross amount bet on all show finishers. Finishers split profit 1/3 and 1/3 and 1/3 (show profit), then divide by gross amount bet on each show finisher for three unique prices.

(2) Net price calculation procedure.

SINGLE PRICE POOL (WIN POOL)

Gross pool	=	sum of wagers on all betting interests – refunds
Takeout	=	gross pool × percent takeout
For each source:		
Net pool	=	gross pool – takeout
Net bet on winner	=	gross amount bet on winner × (1 percent takeout)
Total net pool	=	sum of all sources net pools
Total net bet on winner	=	sum of all sources net bet on winner
Total profit	=	total net pool – total net bet on winner
Profit per dollar	=	total profit/total net bet on winner
$1 unbroken base price	=	profit per dollar + $1
For each source:		
$1 unbroken price	=	$1 unbroken base price × (1 percent takeout)
$1 broken price	=	$1 unbroken price rounded down to the break point
Total payout	=	$1 broken price × gross amount bet on winner
Total breakage	=	net pool – total payout

PROFIT SPLIT (PLACE POOL)

Total profit is the total net pool less the total net amount bet on all place finishers. Finishers split total profit ½ and ½ (place profit), then divide by total net amount bet on each place finisher for two unique unbroken base prices.

PROFIT SPLIT (SHOW POOL)

Total profit is the total net pool less the total net amount bet on all show finishers. Finishers split total profit 1/3 and 1/3 and 1/3 (show profit), then divide by total net amount bet on each show finisher for three unique unbroken base prices.

c. If a profit split results in only one covered winning betting interest or combination, it shall be calculated the same as a single-price pool.

d. Minimum payoffs and the method used for calculating breakage shall be established by the administrator.

e. The individual pools outlined in these rules may be given alternative names by each association, provided prior approval is obtained from the administrator.

8.3(2) *Win pools.*

a. The amount wagered on the betting interest which finishes first is deducted from the net pool, the balance remaining being the profit; the profit is divided by the amount wagered on the betting interest finishing first, such quotient being the profit-per-dollar wagered to win on that betting interest.

b. The net win pool shall be distributed as a single-price pool to winning wagers in the following precedence, based upon the official order of finish:

(1) To those whose selection finished first; but if there are no such wagers, then

(2) To those whose selection finished second; but if there are no such wagers, then

(3) To those whose selection finished third; but if there are no such wagers, then

(4) The entire pool shall be refunded on win wagers for that contest.

c. If there is a dead heat for first involving:

(1) Contestants representing the same betting interest, the win pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the win pool shall be distributed as a profit split.

Table 1: WIN POOL

(Standard Price Calculation)

Sum of wagers on all betting interests =	$194,230.00
Refunds =	$1,317.00
Gross pool:	
Sum of wagers on all betting interests – refunds = ($194,230.00 – $1,317.00)	$192,913.00
Percent takeout =	18%
Takeout: Gross pool × percent takeout = ($192,913.00 × 18%)	$34,724.34
Net pool:	
Gross pool – takeout = ($192,913.00 – $34,724.34)	$158,188.66
Gross amount bet on winner =	$23,872.00
Profit:	
Net pool – gross amount bet on winner = ($158,188.66 – $23,872.00)	$134,316.66
Profit per dollar:	
Profit/gross amount bet on winner = ($134,316.66/$23,872.00)	$5.6265357
$1 unbroken price:	
Profit per dollar + $1 = ($5.6265357 + $1)	$6.6265357
Round off to nearest $0.05 =	$0.0265357
$1 broken price:	
$1 unbroken price – round off to nearest $1.10 =	$6.60

Total payout:	
$1 broken price × gross amount bet on winner = ($6.60 × $23,872.00)	$157,555.20
Total breakage:	
Net pool – total payout = ($158,188.66 – $157,555.20)	$633.46
$2 broken price:	
$1 broken price × 2 = ($6.60 × 2)	$13.20

8.3(3) *Place pools.*

a. The amounts wagered to place on the first two betting interests to finish are deducted from the net pool, the balance remaining being the profit; the profit is divided into two equal portions, one being assigned to each winning betting interest and divided by the amount wagered to place on that betting interest, the resulting quotient being profit per dollar wagered to place on that betting interest.

b. The net place pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) If contestants of a coupled entry or mutuel field finished in the first two places, as a single-price pool to those who selected the coupled entry or mutuel field; otherwise

(2) As a profit split to those whose selection is included within the first two finishers; but if there are no such wagers on one of those two finishers, then

(3) As a single-price pool to those who selected the one covered betting interest included within the first two finishers; but if there are no such wagers, then

(4) As a single-price pool to those who selected the third-place finisher; but if there are no such wagers, then

(5) The entire pool shall be refunded on place wagers for that contest.

c. If there is a dead heat for first involving:

(1) Contestants representing the same betting interest, the place pool shall be distributed as a single-price pool.

(2) Contestants representing two or more betting interests, the place pool shall be distributed as a profit split.

d. If there is a dead heat for second involving:

(1) Contestants representing the same betting interest, the place pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the place pool is divided with one-half of the profit distributed to place wagers on the betting interest finishing first and the remainder is distributed equally among place wagers on those betting interests involved in the dead heat for second.

Table 2: PLACE POOL
(Standard Price Calculation)

Sum of wagers on all betting interests =	$194,230.00
Refunds =	$1,317.00
Gross pool:	
Sum of wagers on all betting interests – refunds =	$192,913.00
Percent takeout =	18%
Takeout: Gross pool × percent takeout =	$34,724.34
Net pool:	
Gross pool – takeout =	$158,188.66
Gross amount bet on 1st place finisher =	$23,872.00

Gross amount bet on 2nd place finisher =	$12,500.00
Profit:	
Net pool – gross amount bet on 1st place finisher – gross amount bet on 2nd place finisher =	$121,816.66
Place profit:	
Profit/2 =	$60,908.33
Profit per dollar for 1st place:	
Place profit/gross amount bet on 1st place finisher =	$2.5514548
$1 unbroken price for 1st place:	
Profit per dollar for 1st place + $1 =	$3.5514548
Profit per dollar for 2nd place:	
Place profit/gross amount bet on 2nd place finisher =	$4.8726664
$1 unbroken price for 2nd place:	
Profit per dollar for 2nd place + $1 =	$5.8726664

8.3(4) *Show pools.*

a. The amounts wagered to show on the first three betting interests to finish are deducted from the net pool, the balance remaining being the profit; the profit is divided into three equal portions, one being assigned to each winning betting interest and divided by the amount wagered to show on that betting interest, the resulting quotient being the profit per dollar wagered to show on that betting interest.

b. The net show pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) If contestants of a coupled entry or mutuel field finished in the first three places, as a single price pool to those who selected the coupled entry or mutuel field; otherwise

(2) If contestants of a coupled entry or mutuel field finished as two of the first three finishers, the profit is divided with two-thirds distributed to those who selected the coupled entry or mutuel field and one-third distributed to those who selected the other betting interest included within the first three finishers; otherwise

(3) As a profit split to those whose selection is included within the first three finishers; but if there are no such wagers on one of those finishers, then

(4) As a profit split to those who selected one of the two covered betting interests included within the first three finishers; but if there are no such wagers on two of those three finishers, then

(5) As a single-price pool to those who selected the one covered betting interest included within the first three finishers; but if there are no such wagers, then

(6) As a single-price pool to those who selected the fourth-place finisher; but if there are no such wagers, then

(7) The entire pool shall be refunded on show wagers for that contest.

c. If there is a dead heat for first involving:

(1) Two contestants representing the same betting interest, the profit is divided with two-thirds distributed to those who selected the first-place finishers and one-third distributed to those who selected the betting interest finishing third.

(2) Three contestants representing a single betting interest, the show pool shall be distributed as a single-price pool.

(3) Contestants representing two or more betting interests, the show pool shall be distributed as a profit split.

d. If there is a dead heat for second involving:

(1) Contestants representing the same betting interest, the profit is divided with one-third distributed to those who selected the betting interest finishing first and two-thirds distributed to those who selected the second-place finishers.

(2) Contestants representing two betting interests, the show pool shall be distributed as a profit split.

(3) Contestants representing three betting interests, the show pool is divided with one-third of the profit distributed to show wagers on the betting interest finishing first and the remainder is distributed equally among show wagers on those betting interests involved in the dead heat for second.

e. If there is a dead heat for third involving:

(1) Contestants representing the same betting interest, the show pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the show pool is divided with two-thirds of the profit distributed to show wagers on the betting interests finishing first and second and the remainder is distributed equally among show wagers on those betting interests involved in the dead heat for third.

Table 3: SHOW POOL
(Standard Price Calculation)

Sum of wagers on all betting interests =	$194,230.00
Refunds =	$1,317.00
Gross pool:	
Sum of wagers on all betting interests – refunds =	$192,913.00
Percent takeout =	18%
Takeout:	
Gross pool × percent takeout =	$34,724.34
Net pool:	
Gross pool – takeout =	$158,188.66
Gross amount bet on 1st place finisher =	$23,872.00
Gross amount bet on 2nd place finisher =	$12,500.00
Gross amount bet on 3rd place finisher =	$4,408.00
Profit:	
Net pool – gross amount bet on 1st place finisher – gross amount bet on 2nd place finisher – gross amount bet on 3rd place finisher =	$117,408.66
Show profit:	
Profit/3 =	$39,136.22
Profit per dollar for 1st place:	
Show profit/gross amount bet on 1st place finisher =	$1.6394194
$1 unbroken price for 1st place:	
Profit per dollar for 1st place + $1 =	$2.6394194
Profit per dollar for 2nd place:	
Show profit/gross amount bet on 2nd place finisher =	$3.1308976
$1 unbroken price for 2nd place:	
Profit per dollar for 2nd place + $1 =	$4.1308976
Profit per dollar for 3rd place:	
Show profit/gross amount bet on 3rd place finisher =	$8.8784528
$1 unbroken price for 3rd place:	
Profit per dollar for 3rd place + $1 =	$9.8784528

Table 4: SHOW POOL
Single Takeout Rate & Single Betting Source
(Single Price Calculation)

Sum of wagers on all betting interests =	$194,230.00
Refunds =	$1,317.00
Gross pool:	
Sum of wagers on all betting interests – refunds =	$192,913.00
Takeout:	
Gross pool × percent takeout =	$34,724.34
Percent takeout =	18%
Total net pool:	
Gross pool – takeout =	$158,188.66
Gross amount bet on 1st place finisher =	$23,872.00
Net amount bet on 1st place finisher =	$19,575.04
Gross amount bet on 2nd place finisher =	$12,500.00
Net amount bet on 2nd place finisher =	$10,250.00
Gross amount bet on 3rd place finisher =	$4,408.00
Net amount bet on 3rd place finisher =	$3,614.56
Total net bet on winners:	
Net amount bet on 1st place finisher +	
Net amount bet on 2nd place finisher +	
Net amount bet on 3rd place finisher =	$33,439.60
Total profit:	
Total net pool – total net bet on winners =	$124,749.06
Show profit:	
Total profit/3 =	$41,583.02
Profit per dollar for 1st place:	
Show profit/net amount bet on 1st place finisher =	$2.1242879
$1 unbroken base price for 1st place:	
Profit per dollar for 1st place + $1 =	$3.1242879
$1 unbroken price for 1st place:	
$1 unbroken base price for 1st place ×	
(1 percent takeout) =	$2.5619161
Profit per dollar for 2nd place:	
Show profit/net amount bet on 2nd place finisher =	$.0568800
$1 unbroken base price for 2nd place:	
Profit per dollar for 2nd place + $1 =	$5.0568800
$1 unbroken price for 2nd place:	
$1 unbroken base price for 2nd place ×	
(1 percent takeout) =	$4.1466416
Profit per dollar for 3rd place:	
Show profit/net amount bet on 3rd place finisher =	$11.504310
$1 unbroken base price for 3rd place:	
Profit per dollar for 3rd place + $1 =	$12.504310
$1 unbroken price for 3rd place:	
$1 unbroken base price for 3rd place ×	
(1 percent takeout) =	$10.253534

8.3(5) *Double pools.*

a. The double requires selection of the first-place finisher in each of two specified contests.

b. The net double pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) As a single-price pool to those whose selection finished first in each of the two contests; but if there are no such wagers, then

(2) As a profit split to those who selected the first-place finisher in either of the two contests; but if there are no such wagers, then

(3) As a single-price pool to those who selected the one covered first-place finisher in either contest; but if there are no such wagers, then

(4) As a single-price pool to those whose selection finished second in each of the two contests; but if there are no such wagers, then

(5) The entire pool shall be refunded on double wagers for those contests.

c. If there is a dead heat for first in either of the two contests involving:

(1) Contestants representing the same betting interest, the double pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the double pool shall be distributed as a profit split if there is more than one covered winning combination.

d. Should a betting interest in the first half of the double be scratched prior to the first double contest being declared official, all money wagered on combinations including the scratched betting interest shall be deducted from the double pool and refunded.

e. Should a betting interest in the second half of the double be scratched prior to the close of wagering on the first double contest, all money wagered on combinations including the scratched betting interest shall be deducted from the double pool and refunded.

f. Should a betting interest in the second half of the double be scratched after the close of wagering on the first double contest, all wagers combining the winner of the first contest with the scratched betting interest in the second contest shall be allocated a consolation payoff. In calculating the consolation payoff the net double pool shall be divided by the total amount wagered on the winner of the first contest and an unbroken consolation price obtained. The broken consolation price is multiplied by the dollar value of wagers on the winner of the first contest combined with the scratched betting interest to obtain the consolation payoff. Breakage is not declared in this calculation. The consolation payoff is deducted from the net double pool before calculation and distribution of the winning double payoff. Dead heats including separate betting interests in the first contest shall result in a consolation payoff calculated as a profit split.

g. If either of the double contests is canceled prior to the first double contest, or the first double contest is declared "no contest," the entire double pool shall be refunded on double wagers for those contests.

h. If the second double contest is canceled or declared "no contest," after the conclusion of the first double contest, the net double pool shall be distributed as a single-price pool to wagers selecting the winner of the first double contest. In the event of a dead heat involving separate betting interests, the net double pool shall be distributed as a profit split.

Table 5: DOUBLE POOL
(Standard Price Calculation)

Sum of wagers on all betting interests =	$194,230.00
Refunds =	$1,317.00
Gross pool: Sum of wagers on all betting interests – refunds =	$192,913.00
Percent takeout =	18%
Takeout: Gross pool × percent takeout =	$34,724.34
Net pool: Gross pool – takeout =	$158,188.66
Gross amount bet on winning combination =	$23,872.00
Profit: Net pool – gross amount bet on winning combination =	$134,316.66
Profit per dollar: Profit/gross amount bet on winning combination =	$5.6265357
$1 unbroken price: Profit per dollar + $1 =	$6.6265357

Table 6: DOUBLE POOL
CONSOLATION PRICING

Sum of wagers on all betting interests =	$194,230.00
Refunds =	$1,317.00
Gross pool: Sum of wagers on all betting interests – refunds =	$192,913.00
Percent takeout =	18%
Takeout: Gross pool × percent takeout =	$34,724.34
Net pool: Gross pool – takeout =	$158,188.66
Consolation pool: Sum total amount bet on winner of the first contest with all second contest betting interests =	$43,321.00
$1 consolation unbroken consolation price: Net pool/consolation pool =	$3.6515468
$1 consolation broken price =	$3.65
Amount bet on winner of the first contest with scratched betting interests:	$1,234.00
Consolation liability: $1 consolation broken price × (amount bet on the winner of the first contest with scratched betting interests) =	$4,504.10
Adjusted net pool: Net pool – consolation liability =	$153,684.56
Gross amount bet on the winning combination =	$23,872.00
Profit: Adjusted net pool – gross amount bet on the winning combination =	$129,812.56
Profit per dollar: Profit/gross amount bet on the winning combination =	$5.4378586
$1 unbroken price: Profit per dollar + $1 =	$6.4378586

8.3(6) *Pick three pools.*

a. The pick three requires selection of the first-place finisher in each of three specified contests.

b. The net pick three pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) As a single-price pool to those whose selection finished first in each of the three contests; but if there are no such wagers, then

(2) As a single-price pool to those who selected the first-place finisher in any two of the three contests; but if there are no such wagers, then

(3) As a single-price pool to those who selected the first-place finisher in any one of the three contests; but if there are no such wagers, then

(4) The entire pool shall be refunded on pick three wagers for those contests.

c. If there is a dead heat for first in any of the three contests involving:

(1) Contestants representing the same betting interest, the pick three pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the pick three pool shall be distributed as a single-price pool with each winning wager receiving an equal share of the profit.

d. Should a betting interest in any of the three pick three contests be scratched, the actual favorite, as evidenced by total amounts wagered in the win pool at the close of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the win-pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalizator shall produce reports showing each of the wagering combinations with substituted betting interests which became winners as a result of the substitution, in addition to the normal winning combination.

e. If all three pick three contests are canceled or declared "no contest," the entire pool shall be refunded on pick three wagers for those contests.

f. If one or two of the pick three contests are canceled or declared "no contest," the pick three pool will remain valid and shall be distributed in accordance with 8.3(6)*"b."*

8.3(7) *Pick (n) pool.*

a. The pick (n) requires selection of the first-place finisher in each of a designated number of contests. The association must obtain written approval from the administrator concerning the scheduling of pick (n) contests, the designation of one of the methods prescribed in 8.3(7)*"b,"* and the amount of any cap to be set on the carryover. Any changes to the approved pick (n) format require prior approval from the administrator.

b. The pick (n) pool shall be apportioned under one of the following methods:

(1) Method 1, pick (n) with carryover. The net pick (n) pool and carryover, if any, shall be distributed as a single-price pool to those who selected the first-place finisher in each of the pick (n) contests, based upon the official order of finish. If there are no such wagers, then a designated percentage of the net pool shall be distributed as a single-price pool of those who selected the first-place finisher in the greatest number of pick (n) contests; and the remainder shall be added to the carryover.

(2) Method 2, pick (n) with minor pool and carryover. The major share of the net pick (n) pool and the carryover, if any, shall be distributed to those who selected the first-place finisher in each of the pick (n) contests, based upon the official order of finish. The minor share of the net pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher of all pick (n) contests, the minor share of the net pick (n) pool shall be distributed as a single-price pool to those who selected the first-place finisher in the greatest number of pick (n) contests; and the major share shall be added to the carryover.

(3) Method 3, pick (n) with no minor pool and no carryover. The net pick (n) pool shall be distributed as a single-price pool to those who selected the first-place finisher in the greatest number of pick (n) contests, based upon the official order of finish. If there are no winning wagers, the pool is refunded.

(4) Method 4, pick (n) with minor pool and no carryover. The major share of the net pick (n) pool shall be distributed to those who selected the first-place finisher in the greatest number of pick (n) contests, based upon the official order of finish. The minor share of the net pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher in a second greatest number of pick (n) contests, the minor share of the net pick (n) pool shall be combined with the major share for distribution as a single-price pool to those who selected the first-place finisher in the greatest number of pick (n) contests. If the greatest number of first-place finishers selected is one, the major and minor shares are combined for distribution as a single-price pool. If there are no winning wagers, the pool is refunded.

(5) Method 5, pick (n) with minor pool and no carryover. The major share of net pick (n) pool shall be distributed to those who selected the first-place finisher in each of the pick (n) contests, based upon the official order of finish. The minor share of the net pick (n) pool shall be distributed to those who selected the first-place finisher in the second greatest number of pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first-place finisher in all pick (n) contests, the entire net pick (n) pool shall be distributed as a single-price pool to those who selected the first-place finisher in the greatest number of pick (n) contests. If there are no wagers selecting the first-place finisher in a second greatest number of pick (n) contests, the minor share of the net pick (n) pool shall be combined with the major share for distribution as a single-price pool to those who selected the first-place finisher in each of the pick (n) contests. If there are no winning wagers, the pool is refunded.

c. If there is a dead heat for first in any of the pick (n) contests involving:

(1) Contestants representing the same betting interest, the pick (n) pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the pick (n) pool shall be distributed as a single-price pool with each winning wager receiving an equal share of the profit.

d. Should a betting interest in any of the pick (n) contests be scratched, the actual favorite, as evidenced by total amounts wagered in the win pool at the host association for the contest at the close of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the win pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalizator shall produce reports showing each of the wagering combinations with substituted betting interests which became winners as a result of the substitution, in addition to the normal winning combination.

e. The pick (n) pool shall be canceled and all pick (n) wagers for the individual performance shall be refunded if:

(1) At least two contests included as part of the pick three are canceled or declared "no contest."

(2) At least three contests included as part of a pick four, pick five, or pick six are canceled or declared "no contest."

(3) At least four contests included as part of a pick seven, pick eight, or pick nine are canceled or declared "no contest."

(4) At least five contests included as part of a pick ten are canceled or declared "no contest."

f. If at least one contest included as part of a pick (n) is canceled or declared "no contest," but not more than the number specified in 8.3(7)*"e,"* the net pool shall be distributed as a single-price pool to those whose selection finished first in the greatest number of pick (n) contests for that performance. Such distribution shall include the portion ordinarily retained for the pick (n) carryover but not the carryover from previous performances.

g. The pick (n) carryover may be capped at a designated level approved by the administrator so that if, at the close of any performance, the amount in the pick (n) carryover equals or exceeds the designated cap, the pick (n) carryover will be frozen until it is won or distributed under other provisions of this rule. After the pick (n) carryover is frozen, 100 percent of the net pool, part of which ordinarily would be added to the pick (n) carryover, shall be distributed to those whose selection finished first in the greatest number of pick (n) contests for that performance.

h. A written request for permission to distribute the pick (n) carryover on a specific performance may be submitted to the administrator. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.

i. Should the pick (n) carryover be designated for distribution on a specified date and performance in which there are no wagers selecting the first-place finisher in each of the pick (n) contests, the entire pool shall be distributed as a single-price pool to those whose selection finished first in the greatest number of pick (n) contests. The pick (n) carryover shall be designated for distribution on a specified date and performance only under the following circumstances:

(1) Upon written approval from the administrator as provided in 8.3(7)*"h."*

(2) Upon written approval from the administrator when there is a change in the carryover cap, a change from one type of pick (n) wagering to another, or when the pick (n) is discontinued.

(3) On the closing performance of the meet or split meet.

j. If, for any reason, the pick (n) carryover must be carried over to the corresponding pick (n) pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the administrator. The pick (n) carryover plus accrued interest shall then be added to the net pick (n) pool of the following meet on a date and performance so designated by the administrator.

k. With the written approval of the administrator, the association may contribute to the pick (n) carryover a sum of money up to the amount of any designated cap.

l. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of live tickets remaining is strictly prohibited, unless permission has been granted by the administrator. This shall not prohibit necessary communication between totalizator and pari-mutuel department employees for processing of pool data.

m. The association may suspend previously approved pick (n) wagering with the prior approval of the administrator. Any carryover shall be held until the suspended pick (n) wagering is reinstated. An association may request approval of a pick (n) wager or separate wagering pool for specific performances.

Table 7: PICK SEVEN POOL
Multiple Takeout Rates & Multiple Betting Sources
(Net Price Calculation)

	Percent Takeout	Gross Pool	Gross Amt. Bet on Win.	Net Pool	Net Amt. Bet on Win.
Source 1:	16%	$190,000.00	$ 44.00	$159,600.00	$ 36.96
Source 2:	18.5%	$ 10,000.00	$ 18.00	$ 8,150.00	$ 14.67
Source 3:	21%	$525,730.00	$124.00	$415,326.70	$ 97.96
TOTALS:		$725,730.00	$186.00	$583,076.70	$149.59

Total profit: Total net pool – total net bet on the winning combination =	$ 582,927.11
Profit per dollar: Total profit/total net bet on the winning combination =	$ 3,896.8321
$1 unbroken base price: Profit per dollar + $1 =	$ 3,897.8321
$1 unbroken price for source 1: $1 unbroken base price × (1 – percent takeout) =	$ 3,274.1789
$1 unbroken price for source 2: $1 unbroken base price × (1 – percent takeout) =	$ 3,176.7331
$1 unbroken price for source 3: $1 unbroken base price × (1 – percent takeout) =	$ 3,079.2873

8.3(8) *Place pick (n) pools.*

a. The place pick (n) requires selection of the first- or second-place finisher in each of a designated number of contests. The association must obtain written approval from the administrator concerning the

scheduling of place pick (n) contests, the designation of one of the methods prescribed in 8.3(8)*"b,"* the distinctive name identifying the pool and the amount of any cap to be set on the carryover. Any changes to the approved place pick (n) format require prior approval from the administrator.

b. The place pick (n) pool shall be apportioned under one of the following methods:

(1) Method 1, pick (n) with carryover. The net place pick (n) pool and carryover, if any, shall be distributed as a single-price pool to those who selected the first- or second-place finisher in each of the place pick (n) contests, based upon the official order of finish. If there are no such wagers, then a designated percentage of the net pool shall be distributed as a single-price pool of those who selected the first- or second-place finisher in the greatest number of place pick (n) contests; and the remainder shall be added to the carryover.

(2) Method 2, place pick (n) with minor pool and carryover. The major share of the net place pick (n) pool and the carryover, if any, shall be distributed to those who selected the first- or second-place finisher in each of the place pick (n) contests, based upon the official order of finish. The minor share of the net place pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the second greatest number of place pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first- or second-place finisher of all place pick (n) contests, the minor share of the net place pick (n) pool shall be distributed as a single-price pool to those who selected the first- or second-place finisher in the greatest number of place pick (n) contests; and the major share shall be added to the carryover.

(3) Method 3, place pick (n) with no minor pool and no carryover. The net place pick (n) pool shall be distributed as a single-price pool to those who selected the first- or second-place finisher in the greatest number of place pick (n) contests, based upon the official order of finish. If there are no winning wagers, the pool is refunded.

(4) Method 4, place pick (n) with minor pool and no carryover. The major share of the net place pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the greatest number of place pick (n) contests, based upon the official order of finish. The minor share of the net place pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the second greatest number of place pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first- or second-place finisher in a second greatest number of place pick (n) contests, the minor share of the net place pick (n) pool shall be combined with the major share for distribution as a single-price pool to those who selected the first- or second-place finisher in the greatest number of place pick (n) contests. If the greatest number of first- or second-place finishers selected is one, the major and minor shares are combined for distribution as a single-price pool. If there are no winning wagers, the pool is refunded.

(5) Method 5, place pick (n) with minor pool and no carryover. The major share of net place pick (n) pool shall be distributed to those who selected the first- or second-place finisher in each of the place pick (n) contests, based upon the official order of finish. The minor share of the net place pick (n) pool shall be distributed to those who selected the first- or second-place finisher in the second greatest number of place pick (n) contests, based upon the official order of finish. If there are no wagers selecting the first- or second-place finisher in all place pick (n) contests, the entire net place pick (n) pool shall be distributed as a single-price pool to those who selected the first- or second-place finisher in the greatest number of place pick (n) contests. If there are no wagers selecting the first- or second-place finisher in a second greatest number of place pick (n) contests, the minor share of the net place pick (n) pool shall be combined with the major share for distribution as a single-price pool to those who selected the first-place finisher in each of the place pick (n) contests. If there are no winning wagers, the pool is refunded.

c. If there is a dead heat for first in any of the place pick (n) contests involving:

(1) Contestants representing the same betting interest, the place pick (n) pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the place pick (n) pool shall be distributed as a single-price pool with each winning wager including each betting interest participating in the dead heat.

d. If there is a dead heat for second in any of the place pick (n) contests involving:

(1) Contestants representing the same betting interest, the place pick (n) pool shall be distributed as if no dead heat occurred.

(2) Contestants representing two or more betting interests, the place pick (n) pool shall be distributed as a single-price pool with a winning wager including the betting interest which finished first or any betting interest involved in the dead heat for second.

e. Should a betting interest in any of the place pick (n) contests be scratched, the actual favorite, as evidenced by total amounts wagered in the win pool at the host association for the contest at the close of wagering on that contest, shall be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the win pool total for two or more favorites is identical, the substitute selection shall be the betting interest with the lowest program number. The totalizator shall produce reports showing each of the wagering combinations with substituted betting interests which became winners as a result of the substitution, in addition to the normal winning combination.

f. The place pick (n) pool shall be canceled and all place pick (n) wagers for the individual performance shall be refunded if:

(1) At least two contests included as part of a pick three are canceled or declared "no contest."

(2) At least three contests included as part of a pick four, pick five, or pick six are canceled or declared "no contest."

(3) At least four contests included as part of a pick seven, pick eight, or pick nine are canceled or declared "no contest."

(4) At least five contests included as part of a pick ten are canceled or declared "no contest."

g. If at least one contest included as part of a place pick (n) is canceled or declared "no contest," but not more than the number specified in 8.3(8)*"f,"* the net pool shall be distributed as a single-price pool to those whose selection finished first or second in the greatest number of place pick (n) contests for that performance. Such distribution shall include the portion ordinarily retained for the place pick (n) carryover but not the carryover from previous performances.

h. The place pick (n) carryover may be capped at a designated level approved by the administrator so that if, at the close of any performance, the amount in the place pick (n) carryover equals or exceeds the designated cap, the place pick (n) carryover will be frozen until it is won or distributed under other provisions of this subrule. After the place pick (n) carryover is frozen, 100 percent of the net pool, part of which ordinarily would be added to the place pick (n) carryover, shall be distributed to those whose selection finished first or second in the greatest number of place pick (n) contests for that performance.

i. A written request for permission to distribute the place pick (n) carryover on a specific performance may be submitted to the administrator. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.

j. Should the place pick (n) carryover be designated for distribution on a specified date and performance in which there are no wagers selecting the first- or second-place finisher in each of the place pick (n) contests, the entire pool shall be distributed as a single-price pool to those whose selection finished first or second in the greatest number of place pick (n) contests. The place pick (n) carryover shall be designated for distribution on a specified date and performance only under the following circumstances:

(1) Upon written approval from the administrator as provided in 8.3(8)*"i."*

(2) Upon written approval from the administrator when there is a change in the carryover cap, a change from one type of place pick (n) wagering to another, or when the place pick (n) is discontinued.

(3) On the closing performance of the meet or split meet.

k. If, for any reason, the place pick (n) carryover must be carried over to the corresponding place pick (n) pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the administrator. The place pick (n) carryover plus accrued interest shall then be added to the net place pick (n) pool of the following meet on a date and performance so designated by the administrator.

l. With the written approval of the administrator, the association may contribute to the place pick (n) carryover a sum of money up to the amount of any designated cap.

m. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of live tickets remaining is strictly prohibited, unless permission has been granted by the administrator. This shall not prohibit necessary communication between totalizator and pari-mutuel department employees for processing of pool data.

n. The association may suspend previously approved place pick (n) wagering with the prior approval of the administrator. Any carryover shall be held until the suspended place pick (n) wagering is reinstated. An association may request approval of a place pick (n) wager or separate wagering pool for specific performances.

8.3(9) *Quinella pools.*

a. The quinella requires selection of the first two finishers, irrespective of order, for a single contest.

b. The net quinella pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) If contestants of a coupled entry or mutuel field finish as the first two finishers, as a single-price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish; otherwise

(2) As a single-price pool to those whose combination finished as the first two betting interests; but if there are no such wagers, then

(3) As a profit split to those whose combination included either the first- or second-place finisher; but if there are no such wagers on one of those two finishers, then

(4) As a single-price pool to those whose combination included the one covered betting interest included within the first two finishers; but if there are no such wagers, then

(5) The entire pool shall be refunded on quinella wagers for that contest.

c. If there is a dead heat for first involving:

(1) Contestants representing the same betting interest, the quinella pool shall be distributed to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish.

(2) Contestants representing two betting interests, the quinella pool shall be distributed as if no dead heat occurred.

(3) Contestants representing three or more betting interests, the quinella pool shall be distributed as a profit split.

d. If there is a dead heat for second involving contestants representing the same betting interest, the quinella pool shall be distributed as if no dead heat occurred.

e. If there is a dead heat for second involving contestants representing two or more betting interests, the quinella pool shall be distributed to wagers in the following precedence, based upon the official order of finish:

(1) As a profit split to those combining the winner with any of the betting interests involved in the dead heat for second; but if there is only one combination covered, then

(2) As a single-price pool to those combining the winner with the one covered betting interest involved in the dead heat for second; but if there are no such wagers, then

(3) As a profit split to those combining the betting interests involved in the dead heat for second; but if there are no such wagers, then

(4) As a profit split to those whose combination included the winner and any other betting interest and wagers selecting any of the betting interests involved in the dead heat for second; but if there are no such wagers, then

(5) The entire pool shall be refunded on quinella wagers for that contest.

8.3(10) *Quinella double pools.*

a. The quinella double requires selection of the first two finishers, irrespective of order, in each of two specified contests.

b. The net quinella double pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) If a coupled entry or mutuel field finishes as the first two contestants in either contest, as a single-price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish for that contest, as well as the first two finishers in the alternate quinella double contest; otherwise

(2) As a single-price pool to those who selected the first two finishers in each of the two quinella double contests; but if there are no such wagers, then

(3) As a profit split to those who selected the first two finishers in either of the two quinella double contests; but if there are no such wagers on one of the contests, then

(4) As a single-price pool to those who selected the first two finishers in the one covered quinella double contest; but if there are no such wagers, then

(5) The entire pool shall be refunded on quinella double wagers for those contests.

c. If there is a dead heat for first in either of the two quinella double contests involving:

(1) Contestants representing the same betting interest, the quinella double pool shall be distributed to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish for that contest.

(2) Contestants representing two betting interests, the quinella double pool shall be distributed as if no dead heat occurred.

(3) Contestants representing three or more betting interests, the quinella double pool shall be distributed as a profit split.

d. If there is a dead heat for second in either of the quinella double contests involving contestants representing the same betting interest, the quinella double pool shall be distributed as if no dead heat occurred.

e. If there is a dead heat for second in either of the quinella double contests involving contestants representing two or more betting interests, the quinella double pool shall be distributed as profit split.

f. Should a betting interest in the first half of the quinella double be scratched prior to the first quinella double contest being declared official, all money wagered on combinations including the scratched betting interest shall be deducted from the quinella double pool and refunded.

g. Should a betting interest in the second half of the quinella double be scratched prior to the close of wagering on the first quinella double contest, all money wagered on combinations including the scratched betting interest shall be deducted from the quinella double pool and refunded.

h. Should a betting interest in the second half of the quinella double be scratched after the close of wagering on the first quinella double contest, all wagers combining the winning combination in the first contest with a combination including the scratched betting interest in the second contest shall be allocated a consolation payoff. In calculating the consolation payoff, the net quinella double pool shall be divided by the total amount wagered on the winning combination in the first contest and an unbroken consolation price obtained. The unbroken consolation price is multiplied by the dollar value of wagers on the winning combination in the first contest combined with a combination including the scratched betting interest in the second contest to obtain the consolation payoff. Breakage is not declared in this calculation. The consolation payoff is deducted from the net quinella double pool before calculation and distribution of the winning quinella double payoff. In the event of a dead heat involving separate betting interests, the net quinella double pool shall be distributed as a profit split.

i. If either of the quinella double contests is canceled prior to the first quinella double contest, or the first quinella double contest is declared "no contest," the entire quinella double pool shall be refunded on quinella double wagers for those contests.

j. If the second quinella double contest is canceled or declared "no contest" after the conclusion of the first quinella double contest, the net quinella double pool shall be distributed as a single-price pool to wagers selecting the winning combination in the first quinella double contest. If there are no wagers selecting the winning combination in the first quinella double contest, the entire quinella double pool shall be refunded on quinella double wagers for those contests.

8.3(11) *Exacta pools.*

a. The exacta requires selection of the first two finishers, in their exact order, for a single contest.

b. The net exacta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) If contestants of a coupled entry or mutuel field finish as the first two finishers, as a single-price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish; otherwise

(2) As a single-price pool to those whose combination finished in correct sequence as the first two betting interests; but if there are no such wagers, then

(3) As a profit split to those whose combination included either the first-place betting interest to finish first or the second-place betting interest to finish second; but if there are no such wagers on one of those two finishers, then

(4) As a single-price pool to those whose combination included the one covered betting interest to finish first or second in the correct sequence; but if there are no such wagers, then

(5) The entire pool shall be refunded on exacta wagers for that contest.

c. If there is a dead heat for first involving:

(1) Contestants representing the same betting interest, the exacta pool shall be distributed as a single-price pool to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish.

(2) Contestants representing two or more betting interests, the exacta pool shall be distributed as a profit split.

d. If there is a dead heat for second involving contestants representing the same betting interest, the exacta pool shall be distributed as if no dead heat occurred.

e. If there is a dead heat for second involving contestants representing two or more betting interests, the exacta pool shall be distributed to ticket holders in the following precedence, based upon the official order of finish:

(1) As a profit split to those combining the first-place betting interest with any of the betting interests involved in the dead heat for second; but if there is only one covered combination, then

(2) As a single-price pool to those combining the first-place betting interest with the one covered betting interest involved in the dead heat for second; but if there are no such wagers, then

(3) As a profit split to those wagers correctly selecting the winner for first place and those wagers selecting any of the dead-heated betting interests for second place; but if there are no such wagers, then

(4) The entire pool shall be refunded on exacta wagers for that contest.

8.3(12) *Trifecta pools.*

a. The trifecta requires selection of the first three finishers, in their exact order, for a single contest.

b. The net trifecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) As a single-price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then

(4) The entire pool shall be refunded on trifecta wagers for that contest.

c. If less than three betting interests finish and the contest is declared official, payoffs will be made based upon the order of finish of those betting interests completing the contest. The balance of any selection beyond the number of betting interests completing the contest shall be ignored.

d. If there is a dead heat for first involving:

(1) Contestants representing three or more betting interests, all of the wagering combinations selecting three or more betting interests which correspond with any of the betting interests involved in the dead heat shall share in a profit split.

(2) Contestants representing two betting interests, both of the wagering combinations selecting the two dead-heated betting interests, irrespective of order, along with the third-place betting interest shall share in a profit split.

e. If there is a dead heat for second, all of the combinations correctly selecting the winner combined with any of the betting interests involved in the dead heat for second shall share in a profit split.

f. If there is a dead heat for third, all wagering combinations correctly selecting the first two finishers, in correct sequence, along with any of the betting interests involved in the dead heat for third shall share in a profit split.

g. Coupled entries and mutuel fields shall be allowed in trifecta contests.

h. Rescinded IAB 10/18/00, effective 11/22/00.

8.3(13) *Superfecta pools.*

a. The superfecta requires selection of the first four finishers, in their exact order, for a single contest.

b. The net superfecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish:

(1) As a single-price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(4) As a single-price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then

(5) The entire pool shall be refunded on superfecta wagers for that contest.

c. If less than four betting interests finish and the contest is declared official, payoffs will be made based upon the order of finish of those betting interests completing the contest. The balance of any selection beyond the number of betting interests completing the contest shall be ignored.

d. If there is a dead heat for first involving:

(1) Contestants representing four or more betting interests, all of the wagering combinations selecting four betting interests which correspond with any of the betting interests involved in the dead heat shall share in a profit split.

(2) Contestants representing three betting interests, all of the wagering combinations selecting the three dead-heated betting interests, irrespective of order, along with the fourth-place betting interest shall share in a profit split.

(3) Contestants representing two betting interests, both of the wagering combinations selecting the two dead-heated betting interests, irrespective of order, along with the third-place and fourth-place betting interests shall share in a profit split.

e. If there is a dead heat for second involving:

(1) Contestants representing three or more betting interests, all of the wagering combinations correctly selecting the winner combined with any of the three betting interests involved in the dead heat for second shall share in a profit split.

(2) Contestants representing two betting interests, all of the wagering combinations correctly selecting the winner, the two dead-heated betting interests, irrespective of order, and the fourth-place betting interests shall share in a profit split.

f. If there is a dead heat for third, all wagering combinations correctly selecting the first two finishers, in correct sequence, along with any two of the betting interests involved in the dead heat for third shall share in a profit split.

g. If there is a dead heat for fourth, all wagering combinations correctly selecting the first three finishers, in correct sequence, along with any of the betting interests involved in the dead heat for fourth shall share in a profit split.

h. Rescinded IAB 6/8/94, effective 7/13/94.

8.3(14) *Twin quinella pools.*

a. The twin quinella requires selection of the first two finishers, irrespective of order, in each of two designated contests. Each winning ticket for the first twin quinella contest must be exchanged for

a free ticket on the second twin quinella contest in order to remain eligible for the second-half twin quinella pool. Such tickets may be exchanged only at attended ticket windows prior to the second twin quinella contest. There will be no monetary reward for winning the first twin quinella contest. Both of the designated twin quinella contests shall be included in only one twin quinella pool.

b. In the first twin quinella contest only, winning wagers shall be determined using the following precedence, based upon the official order of finish for the first twin quinella contest:

(1) If a coupled entry or mutuel field finishes as the first two finishers, those who selected the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish shall be winners; otherwise

(2) Those whose combination finished as the first two betting interests shall be winners; but if there are no such wagers, then

(3) Those whose combination included either the first- or second-place finisher shall be winners; but if there are no such wagers on one of those two finishers, then

(4) Those whose combination included the one covered betting interest included within the first two finishers shall be winners; but if there are no such wagers, then

(5) The entire pool shall be refunded on twin quinella wagers for that contest.

c. In the first twin quinella contest only, if there is a dead heat for first involving:

(1) Contestants representing the same betting interest, those who selected the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish shall be winners.

(2) Contestants representing two betting interests, the winning twin quinella wagers shall be determined as if no dead heat occurred.

(3) Contestants representing three or more betting interests, those whose combination included any two of the betting interests finishing in the dead heat shall be winners.

d. In the first twin quinella contest only, if there is a dead heat for second involving contestants representing two or more betting interests, the twin quinella pool shall be distributed to wagers in the following precedence, based upon the official order of finish:

(1) As a profit split to those combining the winner with any of the betting interests involved in the dead heat for second; but if there is only one covered combination, then

(2) As a single-price pool to those combining the winner with the one covered betting interest involved in the dead heat for second; but if there are no such wagers, then

(3) As a profit split to those combining the betting interests involved in the dead heat for second; but if there are no such wagers, then

(4) As a profit split to those whose combination included the winner and any other betting interest and wagers selecting any of the betting interests involved in the dead heat for second; but if there are no such wagers, then

(5) The entire pool shall be refunded on twin quinella wagers for that contest.

e. In the second twin quinella contest only, the entire net twin quinella pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second twin quinella contest:

(1) If a coupled entry or mutuel field finishes as the first two finishers, as a single-price pool to those who selected the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish; otherwise

(2) As a single-price pool to those whose combination finished as the first two betting interests; but if there are no such wagers, then

(3) As a profit split to those whose combination included either the first- or second-place finisher; but if there are no such wagers on one of those two finishers, then

(4) As a single-price pool to those whose combination included the one covered betting interest included within the first two finishers; but if there are no such wagers, then

(5) As a single-price pool to all the exchange ticket holders for that contest; but if there are no such tickets, then

(6) In accordance with 8.3(10)*"b"* of the quinella double rules.

f. In the second twin quinella contest only, if there is a dead heat for first involving:

(1) Contestants representing the same betting interest, the net twin quinella pool shall be distributed to those selecting the coupled entry or mutuel field combined with the next separate betting interest in the official order of finish.

(2) Contestants representing two betting interests, the net twin quinella pool shall be distributed as if no dead heat occurred.

(3) Contestants representing three or more betting interests, the net twin quinella pool shall be distributed as a profit split to those whose combination included any two of the betting interests finishing in the dead heat.

g. In the second twin quinella contest only, if there is a dead heat for second involving contestants representing two or more betting interests, the twin quinella pool shall be distributed to wagers in the following precedence, based upon the official order of finish:

(1) As a split to those combining the winner with any of the betting interests involved in the dead heat for second; but if there is only one covered combination, then

(2) As a single-price pool to those combining the winner with the one covered betting interest involved in the dead heat for second; but if there are no such wagers, then

(3) As a profit split to those combining the betting interests involved in the dead heat for second; but if there are no such wagers, then

(4) As a profit split to those whose combination included the winner and any other betting interest and wagers selecting any of the betting interests involved in the dead heat for second, then

(5) As a single-price pool to all the exchange ticket holders for that contest; but if there are no such tickets, then

(6) In accordance with 8.3(14)*"b"* of the twin quinella rules.

h. If a winning ticket for the first half of the twin quinella is not presented for exchange prior to the close of betting on the second-half twin quinella contest, the ticket holder forfeits all rights to any distribution of the twin quinella pool resulting from the outcome of the second contest.

i. Contestants representing the same betting interest, the net twin quinella pool shall be distributed as if no dead heat occurred.

j. Should a betting interest in the first half of the twin quinella be scratched, those twin quinella wagers including the scratched betting interest shall be refunded.

k. Should a betting interest in the second half of the twin quinella be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second twin quinella contest, the ticket holder forfeits all rights to the twin quinella pool.

l. If either of the twin quinella contests is canceled prior to the first twin quinella contest, or the first twin quinella contest is declared "no contest," the entire twin quinella pool shall be refunded on twin quinella wagers for that contest.

m. If the second-half twin quinella contest is canceled or declared "no contest" after the conclusion of the first twin quinella contest, the net twin quinella pool shall be distributed as a single-price pool to wagers selecting the winning combination in the first twin quinella contest and all valid exchange tickets. If there are no such wagers, the net twin quinella pool shall be distributed as described in 8.3(14)*"b"* of the twin quinella rules.

8.3(15) *Twin trifecta pools.*

a. The twin trifecta requires selection of the first three finishers, in their exact order, in each of two designated contests. Each winning ticket for the first twin trifecta contest must be exchanged for a free ticket on the second twin trifecta contest in order to remain eligible for the second-half twin trifecta pool. Such tickets may be exchanged only at attended ticket windows prior to the second twin trifecta contest. Winning first-half twin trifecta wagers will receive both an exchange and a monetary payoff. Both of the designated twin trifecta contests shall be included in only one twin trifecta pool.

b. After wagering closes for the first half of the twin trifecta and commissions have been deducted from the pool, the net pool shall then be divided into separate pools: the first-half twin trifecta pool and the second-half twin trifecta pool.

c. In the first twin trifecta contest only, winning wagers shall be determined using the following precedence, based upon the official order of finish for the first twin trifecta contest:

(1) As a single-price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then

(4) The entire twin trifecta pool shall be refunded on twin trifecta wagers for that contest and the second half shall be canceled.

d. If no first-half twin trifecta ticket selects the first three finishers of that contest in exact order, winning ticket holders shall not receive any exchange tickets for the second half of the twin trifecta pool. In such case, the second-half twin trifecta pool shall be retained and added to any existing twin trifecta carryover pool.

e. Winning tickets from the first half of the twin trifecta shall be exchanged for tickets selecting the first three finishers of the second half of the twin trifecta. The second-half twin trifecta pool shall be distributed to winning wagers in the following precedence, based upon the official order for the second twin trifecta contest:

(1) As a single-price pool, including any existing carryover moneys, to those whose combination finished in correct sequence as the first three betting interests; but if there are no such tickets, then

(2) The entire second-half twin trifecta pool for that contest shall be added to any existing carryover moneys and retained for the corresponding second-half twin trifecta pool of the next consecutive performance.

f. If a winning first-half twin trifecta ticket is not presented for cashing and exchange prior to the second-half twin trifecta contest, the ticket holder may still collect the monetary value associated with the first-half twin trifecta pool but forfeits all rights to any distribution of the second-half twin trifecta pool.

g. Coupled entries and mutuel fields shall be allowed in twin trifecta contests.

h. Should a betting interest in the first half of the twin trifecta be scratched, those twin trifecta wagers including the scratched betting interest shall be refunded.

i. Should a betting interest in the second half of the twin trifecta be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second twin trifecta contest, the ticket holder forfeits all rights to the second-half twin trifecta pool.

j. If, due to a late scratch, the number of betting interests in the second half of the twin trifecta is reduced to fewer than the minimum, all exchange tickets and outstanding first-half winning tickets shall be entitled to the second-half twin trifecta pool for that contest as a single-price pool, but not the twin trifecta carryover.

k. If there is a dead heat or multiple dead heats in either the first or second half of the twin trifecta, all twin trifecta wagers selecting the correct order of finish, counting a betting interest involved in a dead heat as finishing in any dead-heated position, shall be a winner. In the case of a dead heat occurring in:

(1) The first half of the twin trifecta, the payoff shall be calculated as a profit split.

(2) The second half of the twin trifecta, the payoff shall be calculated as a single-price pool.

l. If either of the twin trifecta contests is canceled prior to the first twin trifecta contest, or the first twin trifecta contest is declared "no contest," the entire twin trifecta pool shall be refunded on twin trifecta wagers for that contest and the second half shall be canceled.

m. If the second-half twin trifecta contest is canceled or declared "no contest," all exchange tickets and outstanding first-half winning twin trifecta tickets shall be entitled to the net twin trifecta pool for that contest as a single-price pool, but not twin trifecta carryover. If there are no such tickets, the net twin trifecta pool shall be distributed as described in 8.3(14)*"c"* of the twin trifecta rules.

n. The twin trifecta carryover may be capped at a designated level approved by the administrator so that if, at the close of any performance, the amount in the twin trifecta carryover equals or exceeds the designated cap, the twin trifecta carryover will be frozen until it is won or distributed under other provisions of this subrule. After the twin trifecta carryover is frozen, 100 percent of the net twin trifecta pool for each individual contest shall be distributed to winners of the first half of the twin trifecta pool.

o. A written request for permission to distribute the twin trifecta carryover on a specific performance may be submitted to the administrator. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.

p. Should the twin trifecta carryover be designated for distribution on a specified date and performance, the following precedence will be followed in determining winning tickets for the second half of the twin trifecta after completion of the first half of the twin trifecta:

(1) As a single-price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then

(4) As a single-price pool to holders of valid exchange tickets.

(5) As a single-price pool to holders of outstanding first-half winning tickets.

q. Contrary to 8.3(14)*"d"* of the twin trifecta rules, during a performance designated to distribute the twin trifecta carryover, exchange tickets will be issued for those combinations selecting the greatest number of betting interests in their correct order of finish for the first half of the twin trifecta. If there are no wagers correctly selecting the first-, second-, and third-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first- and second-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-place betting interest only. If there are no wagers selecting the first-place betting interest only in the first half of the twin trifecta, all first-half tickets will become winners and will receive 100 percent of that day's net twin trifecta pool and any existing twin trifecta carryover as a single-price pool.

r. The twin trifecta carryover shall be designated for distribution on a specified date and performance only under the following circumstances:

(1) Upon written approval from the administrator as provided in 8.3(14)*"o"* of the twin trifecta rules.

(2) Upon written approval from the administrator when there is a change in the carryover cap or when the twin trifecta is discontinued.

(3) On the closing performance of the meet or split meet.

s. If, for any reason, the twin trifecta carryover must be carried over to the corresponding twin trifecta pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the administrator. The twin trifecta carryover plus accrued interest shall then be added to the second-half twin trifecta pool of the following meet on a date and performance so designated by the administrator.

t. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of valid exchange tickets is prohibited, unless permission is granted by the administrator. This shall not prohibit necessary communication between totalizator and pari-mutuel department employees' processing of pool data.

u. The association must obtain written approval from the administrator concerning the scheduling of twin trifecta contests, the percentages of the net pool added to the first-half pool and second-half pool, and the designated amount of any cap to be set on the carryover. Any subsequent changes to the twin trifecta rules require prior approval from the administrator.

8.3(16) *Tri-superfecta pools.*

a. The tri-superfecta requires selection of the first three finishers, in their exact order, in the first of two designated contests and the first four finishers, in exact order, in the second of the two designated

contests. Each winning ticket for the first tri-superfecta contest must be exchanged for a free ticket on the second tri-superfecta contest in order to remain eligible for the second-half tri-superfecta pool. Such tickets may be exchanged only at attended ticket windows prior to the second tri-superfecta contest. Winning first-half tri-superfecta tickets will receive both an exchange and a monetary payoff. Both of the designated tri-superfecta contests shall be included in only one tri-superfecta pool.

b. After wagering closes for the first half of the tri-superfecta and commissions have been deducted from the pool, the net pool shall then be divided into two separate pools: the first-half tri-superfecta pool and the second-half tri-superfecta pool.

c. In the first tri-superfecta contest only, winning tickets shall be determined using the following precedence, based upon the official order of finish for the first tri-superfecta contest:

(1) As a single-price pool to those whose combination finished in correct sequence as the first three betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then

(4) The entire tri-superfecta pool shall be refunded on tri-superfecta wagers for that contest and the second half shall be canceled.

d. If no first-half tri-superfecta ticket selects the first three finishers of that contest in exact order, winning ticket holders shall not receive any exchange tickets for the second-half tri-superfecta pool. In such case, the second-half tri-superfecta pool shall be retained and added to any existing tri-superfecta carryover pool.

e. Winning tickets from the first half of the tri-superfecta shall be exchanged for tickets selecting the first four finishers of the second half of the tri-superfecta. The second-half tri-superfecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second tri-superfecta contest:

(1) As a single-price pool, including any existing carryover moneys, to those whose combination finished in correct sequence as the first four betting interests; but if there are no such tickets, then

(2) The entire second-half tri-superfecta pool for that contest shall be added to any existing carryover moneys and retained for the corresponding second-half tri-superfecta pool of the next performance.

f. If a winning first-half tri-superfecta ticket is not presented for cashing and exchange prior to the second-half tri-superfecta contest, the ticket holder may still collect the monetary value associated with the first-half tri-superfecta pool but forfeits all rights to any distribution of the second-half tri-superfecta pool.

g. Coupled entries and mutuel fields shall be prohibited in tri-superfecta contests.

h. Should a betting interest in the first half of the tri-superfecta be scratched, those tri-superfecta tickets including the scratched betting interest shall be refunded.

i. Should a betting interest in the second half of the tri-superfecta be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second tri-superfecta contest, the ticket holder forfeits all rights to the second-half tri-superfecta pool.

j. If, due to a late scratch, the number of betting interests in the second half of the tri-superfecta is reduced to fewer than the minimum, all exchange tickets and outstanding first-half winning tickets shall be entitled to the second-half tri-superfecta pool for that contest as a single-price pool, but not the tri-superfecta carryover..

k. If there is a dead heat or multiple dead heats in either the first or second half of the tri-superfecta, all tri-superfecta tickets selecting the correct order of finish, counting a betting interest involved in a dead heat as finishing in any dead-heated position, shall be a winner. In the case of a dead heat occurring in:

(1) The first half of the tri-superfecta, the payoff shall be calculated as a profit split.

(2) The second half of the tri-superfecta, the payoff shall be calculated as a single-price pool.

l. If either of the tri-superfecta contests is canceled prior to the first tri-superfecta contest, or the first tri-superfecta contest is declared "no contest," the entire tri-superfecta pool shall be refunded on tri-superfecta wagers for that contest and the second half shall be canceled.

m. If the second-half tri-superfecta contest is canceled or declared "no contest," all exchange tickets and outstanding first-half winning tri-superfecta tickets shall be entitled to the net tri-superfecta pool for that contest as a single-price pool, but not the tri-superfecta carryover. If there are no such tickets, the net tri-superfecta pool shall be distributed as described in 8.3(16)*"c"* of the tri-superfecta rules.

n. The tri-superfecta carryover may be capped at a designated level approved by the administrator so that if, at the close of any performance, the amount in the tri-superfecta carryover equals or exceeds the designated cap, the tri-superfecta carryover will be frozen until it is won or distributed under other provisions of this subrule. After the second-half tri-superfecta carryover is frozen, 100 percent of the tri-superfecta pool for each individual contest shall be distributed to winners of the first half of the tri-superfecta pool.

o. A written request for permission to distribute the tri-superfecta carryover on a specific performance may be submitted to the administrator. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.

p. Should the tri-superfecta carryover be designated for distribution on a specified date and performance, the following precedence will be followed in determining winning tickets for the second half of the tri-superfecta after completion of the first half of the tri-superfecta:

(1) As a single-price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(4) As a single-price pool to those whose combination included, in correct sequence, the first-place betting interests only; but if there are no such wagers, then

(5) As a single-price pool to holders of valid exchange tickets.

(6) As a single-price pool to holders of outstanding first-half winning tickets.

q. Contrary to 8.3(16)*"d"* of the tri-superfecta rules, during a performance designated to distribute the tri-superfecta carryover, exchange tickets will be issued for those combinations selecting the greatest number of betting interests in their correct order of finish for the first half of the tri-superfecta. If there are no wagers correctly selecting the first-, second-, and third-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first- and second-place betting interests. If there are no wagers correctly selecting the first- and second-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-place betting interest only. If there are no wagers selecting the first-place betting interest only in the first half of the tri-superfecta, all first-half tickets will become winners and will receive 100 percent of the day's net tri-superfecta pool and any existing tri-superfecta carryover as a single-price pool.

r. The tri-superfecta carryover shall be designated for distribution on a specified date and performance only under the following circumstances:

(1) Upon written approval from the administrator as provided in 8.3(16)*"o"* of the tri-superfecta rules.

(2) Upon written approval from the administrator when there is a change in the carryover cap or when the tri-superfecta is discontinued.

(3) On the closing performance of the meet or split meet.

s. If, for any reason, the tri-superfecta carryover must be carried over to the corresponding tri-superfecta pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the administrator. The tri-superfecta carryover plus accrued interest shall then be added to the second-half tri-superfecta pool of the following meet on a date and performance so designated by the administrator.

t. Providing information to any person regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of valid exchange tickets is prohibited, unless permission has been granted by the administrator. This shall not prohibit necessary communication between totalizator and pari-mutuel department employees for processing of pool data.

u. The association must obtain written approval from the administrator concerning the scheduling of tri-superfecta contests, the percentages of the net pool added to the first-half pool and second-half pool, and the designated amount of any cap to be set on the carryover. Any subsequent changes to the tri-superfecta rules require prior approval from the administrator.

8.3(17) *Twin superfecta pools.*

a. The twin superfecta requires selection of the first four finishers, in their exact order, in each of two designated contests. Each winning ticket for the first twin superfecta contest must be exchanged for a free ticket on the second twin superfecta contest in order to remain eligible for the second-half twin superfecta pool. Such tickets may be exchanged only at attended ticket windows prior to the second twin superfecta contest. Winning first-half twin superfecta tickets will receive both an exchange and a monetary payoff. Both of the designated twin superfecta contests shall be included in only one twin superfecta pool.

b. After wagering closes for the first half of the twin superfecta and commissions have been deducted from the pool, the net pool shall then be divided into two separate pools: the first-half twin superfecta pool and the second-half twin superfecta pool.

c. In the first twin superfecta contest only, winning wagers shall be determined using the following precedence, based upon the official order of finish for the first twin superfecta contest:

(1) As a single-price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(4) As a single-price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then

(5) The entire twin superfecta pool shall be refunded on twin superfecta wagers for that contest and the second half shall be canceled.

d. If no first-half twin superfecta ticket selects the first four finishers of that contest in exact order, winning ticket holders shall not receive any exchange tickets for the second-half twin superfecta pool. In such case, the second-half twin superfecta pool shall be retained and added to any existing twin superfecta carryover pool.

e. Winning tickets from the first half of the twin superfecta shall be exchanged for tickets selecting the first four finishers of the second half of the twin superfecta. The second-half twin superfecta pool shall be distributed to winning wagers in the following precedence, based upon the official order of finish for the second twin superfecta contest:

(1) As a single-price pool, including any existing carryover moneys, to those whose combination finished in correct sequence as the first four betting interests; but if there are no such tickets, then

(2) The entire second-half twin trifecta pool for that contest shall be added to any existing carryover moneys and retained for the corresponding second-half twin superfecta pool of the next performance. The additional second-half twin superfecta moneys resulting from such a carryover shall be termed the "twin superfecta carryover."

f. If a winning first-half twin superfecta ticket is not presented for cashing and exchange prior to the second-half twin superfecta contest, the ticket holder may still collect the monetary value associated with the first-half twin superfecta pool but forfeits all rights to any distribution of the second-half twin trifecta pool.

g. Coupled entries and mutuel fields shall be prohibited in twin superfecta contests.

h. Should a betting interest in the first half of the twin superfecta be scratched, those twin superfecta tickets including the scratched betting interest shall be refunded.

i. Should a betting interest in the second half of the twin superfecta be scratched, an announcement concerning the scratch shall be made and a reasonable amount of time shall be provided for exchange of tickets that include the scratched betting interest. If tickets have not been exchanged prior to the close of betting for the second twin superfecta contest, the ticket holder forfeits all rights to the second-half twin superfecta pool.

j. If, due to a late scratch, the number of betting interests in the second half of the twin superfecta is reduced to fewer than the minimum, all exchange tickets and outstanding first-half winning tickets shall be entitled to the second-half twin superfecta pool for that contest as a single-price pool, but not the twin superfecta carryover.

k. If there is a dead heat or multiple dead heats in either the first or second half of the twin superfecta, all twin superfecta tickets selecting the correct order of finish, counting a betting interest involved in a dead heat as finishing in any dead-heated position, shall be a winner. In the case of a dead heat occurring in:

(1) The first half of the twin superfecta, the payoff shall be calculated as a profit split.

(2) The second half of the twin superfecta, the payoff shall be calculated as a single-price pool.

l. If either of the twin superfecta contests are canceled prior to the first twin superfecta contest, or the first twin superfecta contest is declared "no contest," the entire twin superfecta pool shall be refunded on twin superfecta wagers for that contest and the second half shall be canceled.

m. If the second-half twin superfecta contest is canceled or declared "no contest," all exchange tickets and outstanding first-half winning twin superfecta tickets shall be entitled to the net twin superfecta pool for that contest as a single-price pool, but not the twin superfecta carryover. If there are no such tickets, the net twin superfecta pool shall be distributed as described in 8.3(17)*"c"* of the twin superfecta rules.

n. The twin superfecta carryover may be capped at a designated level approved by the administrator so that if, at the close of any performance, the amount in the twin superfecta carryover equals or exceeds the designated cap, the twin superfecta carryover will be frozen until it is won or distributed under other provisions of this subrule. After the second-half twin superfecta carryover is frozen, 100 percent of the net twin superfecta pool for each individual contest shall be distributed to winners of the first half of the twin superfecta pool.

o. A written request for permission to distribute the twin superfecta carryover on a specific performance may be submitted to the administrator. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and performance for the distribution.

p. Should the twin superfecta carryover be designated for distribution of a specified date and performance, the following precedence will be followed in determining winning tickets for the second half of the twin superfecta after completion of the first half of the twin superfecta:

(1) As a single-price pool to those whose combination finished in correct sequence as the first four betting interests; but if there are no such wagers, then

(2) As a single-price pool to those whose combination included, in correct sequence, the first three betting interests; but if there are no such wagers, then

(3) As a single-price pool to those whose combination included, in correct sequence, the first two betting interests; but if there are no such wagers, then

(4) As a single-price pool to those whose combination correctly selected the first-place betting interest only; but if there are no such wagers, then

(5) As a single-price pool to holders of valid exchange tickets.

(6) As a single-price pool to holders of outstanding first-half winning tickets.

q. Contrary to 8.3(17)*"d"* of the twin superfecta rules, during a performance designated to distribute the twin superfecta carryover, exchange tickets will be issued for those combinations selecting the greatest number of betting interests in their correct order of finish for the first half of the twin superfecta. If there are no wagers correctly selecting the first-, second-, third-, and fourth-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-, second-, and third-place betting interests. If there are no wagers correctly selecting the

first-, second-, and third-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first- and second-place betting interests. If there are no wagers correctly selecting the first- and second-place finishers, in their exact order, then exchange tickets shall be issued for combinations correctly selecting the first-place betting interest only. If there are no wagers selecting the first-place betting interest only in the first half of the twin superfecta, all first-half tickets will become winners and will receive 100 percent of that day's net twin superfecta pool and any existing twin superfecta carryover as a single-price pool.

r. The twin superfecta carryover shall be designated for distribution on a specified date and performance only under the following circumstances:

(1) Upon written approval from the administrator as provided in 8.3(17)*"o"* of the twin superfecta rules.

(2) Upon written approval from the administrator when there is a change in the carryover cap or when the twin superfecta is discontinued.

(3) On the closing performance of the meet or split meet.

s. If, for any reason, the twin superfecta carryover must be carried over to the corresponding twin superfecta pool of a subsequent meet, the carryover shall be deposited in an interest-bearing account approved by the administrator. The twin superfecta carryover plus accrued interest shall then be added to the second-half twin superfecta pool of the following meet on a date and performance so designated by the administrator.

t. Providing information to any person regarding covered combinations, amount wagered on specific combinations, number of tickets sold, or number of valid exchange tickets is prohibited, unless permission has been granted by the administrator. This shall not prohibit necessary communication between totalizator and pari-mutuel department employees for processing of pool data.

u. The association must obtain written approval from the administrator concerning the scheduling of twin superfecta contests, the percentages of the net pool added to the first-half pool and second-half pool, and the designated amount of any cap to be set on the carryover. Any subsequent changes to the twin superfecta rules require prior approval from the administrator.

491—8.4(99D) Simulcast wagering.

8.4(1) *General.*

a. Rules. All simulcasting must be transmitted live and all wagering on simulcasting shall be made in accordance with the commission rules on pari-mutuel wagering. Commission rules in effect during live racing shall remain in effect during simulcasting where applicable.

b. Transmission. The method used to transmit sales transaction and pari-mutuel output data must be approved by the commission, based upon the determination that provisions to secure the system and transmission are satisfactory.

c. Communication. A communication system between the host track and the receiving facility must be provided which will allow the totalizator operator and the commission representatives at the host track to communicate with the facility receiving the signal. The association is responsible during the racing program's operating hours for reporting any problems or delays to the public.

d. Approval.

(1) All simulcasting, both interstate and intrastate, must be preapproved by the commission or commission representative. Each association conducting simulcasting shall submit an annual written simulcast proposal to the commission with the application for license renewal required by 491—Chapter 1.

(2) The commission representative, upon written request, may grant modifications to the annual simulcast proposal. The commission representative may approve or disapprove simulcast requests at the representative's discretion. Factors that may be considered include, but are not limited to: economic conditions of an association, impact on other associations, impact on the Iowa breeding industry, other gambling in the state, and any other considerations the commission representative deems appropriate.

(3) Once simulcast authority has been granted by the commission or commission representative, it shall be the affirmative responsibility of the association granted simulcast authority to obtain all necessary

permission from other states and tracks to simulcast the pari-mutuel races. In addition, the burden of adhering to state and federal laws concerning simulcasting rests on the association at all times.

8.4(2) *Simulcast host.*

a. Every host association, if requested, may contract with an authorized receiver for the purpose of providing authorized users its simulcast. All contracts governing participation in interstate or intrastate pools shall be submitted to the commission representative for prior approval. Contracts shall be of such content and in such format as required by the commission representative.

b. A host association is responsible for the content of the simulcast and shall use all reasonable effort to present a simulcast which offers the viewers an exemplary depiction of each performance.

c. Unless otherwise permitted by the commission representative, every simulcast will contain in its video content a digital display of actual time of day, the name of the host facility from which it emanates, the number of the contest being displayed, and any other relevant information available to patrons at the host facility.

d. The host association shall maintain such security controls, including encryption over its uplink and communications systems, as directed or approved by the commission or commission representative.

e. Financial reports shall be submitted daily or as otherwise directed by the commission representative. Reports shall be of such content and in such format as required by the commission representative.

8.4(3) *Authorized receiver.*

a. An authorized receiver shall provide:

(1) Adequate transmitting and receiving equipment of acceptable broadcast quality which shall not interfere with the closed circuit TV system of the host association for providing any host facility patron information.

(2) Pari-mutuel terminals, pari-mutuel odds displays, modems and switching units enabling pari-mutuel data transmissions, and data communications between the host and guest associations.

(3) A voice communication system between each guest association and the host association providing timely voice contact among the commission representative, placing judges, and pari-mutuel departments.

b. The guest association and all authorized receivers shall conduct pari-mutuel wagering pursuant to the applicable commission rules.

c. Not less than 30 minutes prior to the commencement of transmission of the performance of pari-mutuel contests, the guest association shall initiate a test program of its transmitter, encryption and decoding, and data communication to ensure proper operation of the system.

d. The guest association shall, in conjunction with the host association(s) for which it operates pari-mutuel wagering, provide the commission representative with a certified report of its pari-mutuel operations as directed by the commission representative.

e. Every authorized receiver shall file with the commission an annual report of its simulcast operations and an audited financial statement.

f. The mutuel manager shall notify the commission representative when the transfer of pools, pool totals, or calculations are in question, or if partial or total cancellations occur, and shall suggest alternatives for continued operation. Should loss of video signal occur, wagering may continue with approval from the commission representative.

491—8.5(99D) Interstate common-pool wagering.

8.5(1) *General.*

a. All contracts governing participation in interstate common pools shall be submitted to the commission representative for prior approval. Financial reports shall be submitted daily or as otherwise directed by the commission representative. Contracts and reports shall be of such content and in such format as required by the commission representative.

b. Individual wagering transactions are made at the point of sale in the state where placed. Pari-mutuel pools are combined for computing odds and calculating payoffs but will be held separate for auditing and all other purposes.

c. Any surcharges or withholdings in addition to the takeout shall be applied only in the jurisdiction otherwise imposing such surcharges or withholdings.

d. In determining whether to approve an interstate common pool which does not include the host association or which includes contests from more than one association, the commission representative shall consider and may approve use of a bet type which is not utilized at the host association, application of a takeout rate not in effect at the host association, or other factors which are presented to the commission representative.

e. The content and format of the visual display of racing and wagering information at facilities in other jurisdictions where wagering is permitted in the interstate common pool need not be identical to the similar information permitted or required to be displayed under these rules.

8.5(2) *Guest state participation in interstate common pools.*

a. With the prior approval of the commission representative, pari-mutuel wagering pools may be combined with corresponding wagering pools in the host state, or with corresponding pools established by one or more other jurisdictions.

b. The commission representative may permit adjustment of the takeout from the pari-mutuel pool so that the takeout rate in this jurisdiction is identical to that of the host association, or identical to that of other jurisdictions participating in a merged pool.

c. When takeout rates in the merged pools are not identical, the net-price calculation shall be the method by which the differing takeout rates are applied.

d. Rules established in the state of the host association designated for a pari-mutuel pool shall apply.

e. The commission representative shall approve agreements made between the association and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.

f. If, for any reason, it becomes impossible to successfully merge the bets placed into the interstate common pool, the association shall make payoffs in accordance with payoff prices that would have been in effect if prices for the pool of bets were calculated without regard to wagers placed elsewhere; except that, with the permission of the commission representative, the association may alternatively determine either to pay winning tickets at the payoff prices at the host association, or to declare such accepted bets void and make refunds in accordance with the applicable rules.

8.5(3) *Host state participation in merged pools.*

a. With the prior approval of the commission representative, an association licensed to conduct pari-mutuel wagering may determine that one or more of its contests be utilized for pari-mutuel wagering at guest facilities in other states and may also determine that pari-mutuel pools in guest states be combined with corresponding wagering pools established by it as the host association or comparable wagering pools established by two or more states.

b. When takeout rates in the merged pool are identical, the net-price calculation shall be the method by which the differing takeout rates are applied.

c. Rules of racing established for races held in this state shall also apply to interstate common pools unless the commission representative shall specifically determine otherwise.

d. The commission representative shall approve agreements made between the association and other participants in interstate common pools governing the distribution of breakage between the jurisdictions.

e. Any contract for interstate common pools entered into by the association shall contain a provision to the effect that if, for any reason, it becomes impossible to successfully merge the bets placed in another state into the interstate common pool formed by the association or if, for any reason, the commission representative or association determines that attempting to effect transfer of pool data from the guest state may endanger the association's wagering pool, the association shall have no liability for any measure taken which may result in the guest's wagers not being accepted into the pool.

8.5(4) *Takeout rates in interstate common pools.*

a. With the prior approval of the commission representative, an association wishing to participate in an interstate common pool may change its takeout rate so as to achieve a common takeout rate with all other participants in the interstate common pool.

b. An association wishing to participate in an interstate common pool may request that the commission representative approve a methodology whereby host association and guest association states with different takeout rates for corresponding pari-mutuel pools may effectively and equitably combine wagers from the different states into an interstate common pool.

491—8.6(99D) Advance deposit wagering.

8.6(1) *Definitions.*

"Account" means an account approved by the commission for advance deposit wagering with a complete record of credits, wagers and debits established by a licensee account holder and managed by a licensee or ADWO.

"Advance deposit wagering" means a method of pari-mutuel wagering in which an individual may establish an account, deposit money into the account, and use the account balance to pay for pari-mutuel wagering.

"Advance deposit wagering center" means an actual location, equipment, and staff of a licensee, ADWO, or both involved in the management, servicing and operation of advance deposit wagering for the licensee.

"Advance deposit wagering operator" or *"ADWO"* means an advance deposit wagering operator licensed by the commission who has entered into an agreement with the licensee of the horse racetrack in Polk County and the Iowa Horsemen's Benevolent and Protective Association to provide advance deposit wagering.

"Credits" means all positive inflows of money to an account.

"Debits" means all negative outflow of money from an account.

"Deposit" means a payment of money into an account.

"Licensee" means a horse racetrack located in Polk County operating under a license issued by the commission.

"Licensee account holder" means any individual at least 21 years of age who successfully completed an application and for whom the licensee or ADWO has opened an account. "Licensee account holder" does not include any corporation, partnership, limited liability company, trust, estate or other formal or nonformal entity.

"Proper identification" means a form of identification accepted in the normal course of business to establish that the person making a transaction is a licensee account holder.

"Secure personal identification code" means an alpha-numeric character code provided by a licensee account holder as a means by which the licensee or ADWO may verify a wager or account transaction as authorized by the licensee account holder.

"Source market fee" or *"host fee"* means the part of a wager made on any race by a person who is a licensee account holder that is returned to the licensee and the Iowa Horsemen's Benevolent and Protective Association pursuant to the terms of a negotiated agreement as required by these rules.

"Withdrawal" means a payment of money from an account by the licensee or ADWO to the licensee account holder when properly requested by the licensee account holder.

8.6(2) *Authorization to conduct advance deposit wagering.*

a. A licensee may request authorization from the commission to conduct advance deposit wagering pursuant to 2011 Iowa Code Supplement section 99D.11(6)*"c"* and these rules. As part of the request, the licensee shall submit a detailed plan of how its advance deposit wagering system would operate. The commission may require changes in a proposed plan of operations as a condition of granting a request. No subsequent changes in the system's operation may occur unless ordered by the commission or until approval is obtained from the commission after it receives a written request.

b. The commission may conduct investigations or inspections or request additional information from the licensee as the commission deems appropriate in determining whether to allow the licensee to conduct advance deposit wagering.

c. The licensee shall establish and manage an advance deposit wagering center.

d. The commission may issue an ADWO license to an entity that enters into an agreement with the commission, licensee, and the Iowa Horsemen's Benevolent and Protective Association. The terms of any ADWO's license shall include but not be limited to:

(1) Any source market fees and host fees to be paid on any races subject to advance deposit wagering.

(2) An annual ADWO license fee in an amount to be determined by the commission.

(3) Completion of all necessary background investigations.

(4) Acceptance of wagers on live races conducted at the horse racetrack in Polk County from all of its licensee account holders.

(5) A bond or irrevocable letter of credit on behalf of the ADWO to be determined by the commission.

(6) A detailed description and certification of systems and procedures used by the ADWO to validate the identity and age of licensee account holders and to validate the legality of wagers accepted.

(7) Certification of prompt commission access to all records relating to licensee account holder identity and age in hard-copy or standard electronic format acceptable to the commission.

(8) Certification of secure retention of all records related to advance deposit wagering and accounts for a period of not less than three years or such longer period as specified by the commission.

(9) Utilization and communication of pari-mutuel wagers to a pari-mutuel system meeting all requirements for pari-mutuel systems employed by licensed racing facilities in Iowa.

e. Commission access to and use of information concerning advance deposit wager transactions and licensee account holders shall be considered proprietary, and such information shall not be disclosed publicly except as may be required pursuant to statute or court order or except as part of the official record of any proceeding before the commission. This requirement shall not prevent the sharing of this information with other pari-mutuel regulatory authorities or law enforcement agencies for investigative purposes.

f. For each advance deposit wager made for an account by telephone, the licensee or ADWO shall make a voice recording of the entire transaction and shall not accept any such wager if the voice-recording system is inoperable. Voice recordings shall be retained for not less than six months and shall be made available to the commission for investigative purposes.

8.6(3) *Establishing an account.*

a. A person must have an established account in order to place advance deposit wagers. An account may be established in person at the licensee's facility or with the ADWO by mail or electronic means. For establishing an account, the application must be signed or otherwise authorized in a manner acceptable to the commission and shall include: the applicant's full legal name, principal residence address, telephone number, and date of birth and any other information required by the commission.

b. Each application submitted will be subject to electronic verification with respect to the applicant's name, principal residence address and date of birth by either a national, independent individual reference service company or by means of a technology which meets or exceeds the reliability, security, accuracy, privacy and timeliness provided by individual reference service companies. An applicant's social security number may be necessary for completion of the verification process and for tax reporting purposes. If there is a discrepancy between the application submitted and the information provided by the electronic verification or if no information on the applicant is available from such electronic verification, another individual reference service may be accessed or another technology meeting the requirements described above may be used to verify the information provided. If these measures prove unsatisfactory, then the applicant will be contacted and given instructions as to how to resolve the matter.

c. The identity of a licensee account holder must be verified via electronic means or copies of other documents before the licensee account holder may place an advance deposit wager.

d. Each account shall have a unique identifying account number. The identifying account number may be changed at any time by the licensee or ADWO provided that the licensee or ADWO informs the licensee account holder in writing prior to the change.

e. The applicant shall provide the licensee or ADWO with an alpha-numeric code to be used as a secure personal identification code when the licensee account holder is placing an advance deposit wager. The licensee account holder has the right to change this code at any time.

f. The licensee account holder shall receive at the time the account is approved a unique account identification number; a copy of the advance deposit wagering rules and such other information and material pertinent to the operation of the account; and such other information as the licensee, ADWO or commission may deem appropriate.

g. The account is nontransferable.

h. The licensee or ADWO may close or refuse to open an account for what it deems good and sufficient reason and shall order an account closed if it is determined that information used to open an account was false or that the account has been used in violation of these rules or the licensee's or ADWO's terms and conditions.

8.6(4) *Operation of an account.* The ADWO shall submit operating procedures with respect to licensee account holder accounts for commission approval.

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CHAPTER 9
HARNESS RACING

[Prior to 11/9/86, Racing Commission[693]]
[Prior to 11/18/87, Racing and Gaming Division[195]]

491—9.1(99D) Terms defined. As used in these rules, unless the context otherwise requires, the following definitions apply:

"Also eligible" means a number of eligible horses, properly entered, which were not drawn for inclusion in a race, but which become eligible according to preference or lot if an entry is scratched prior to the scratch time deadline; or the next preferred nonqualifier for the finals or consolation from a set of elimination trials, which will become eligible in the event a finalist is scratched by the stewards for a rule violation; or is otherwise eligible if written race conditions permit.

"Arrears" means all moneys owed by a licensee, including subscriptions, forfeitures, and any other payment and default incident to these rules.

"Authorized agent" means a person licensed by the commission as an agent for a horse owner or principal by virtue of a notarized appointment. The agent shall be designated on a form approved by the commission and filed by the owner or principal with the commission authorizing the agent to handle matters pertaining to racing and stabling, including authorization to claim and to withdraw money from the horsemen's bookkeeper.

"Bleeder" means a horse that hemorrhages from within the respiratory tract during a race or within one and one-half hours postrace, during exercise or within one and one-half hours of exercise.

"Bleeder list" means a tabulation of all bleeders to be maintained by the commission.

"Chemist" means any official racing chemist designated by the commission.

"Claiming race" means a race which includes a condition that any horse starting the race may be claimed and purchased by any licensed owner, or person(s) approved by the commission for an owner's license, for the designated amount specified in the conditions for that race by the racing secretary.

"Commission" means the Iowa racing and gaming commission.

"Conditioned race" means any overnight event to which eligibility is determined according to specified qualifications.

"Conditions" means qualifications that determine a horse's eligibility to be entered in a race.

"Contest" means a competitive racing event on which pari-mutuel wagering is conducted.

"Contestant" means an individual participant in a contest.

"Coupled entry" means two or more contestants in a contest that are treated as a single betting interest for pari-mutuel wagering purposes. (See also "Entry.")

"C.T.A." means Canadian Trotting Association.

"Dash" means a race decided in a single trial. Dashes may be given in a series of two or three governed by one entry fee for the series, in which event a horse must start in all dashes. Positions may be drawn for each dash. The number of premiums awarded shall not exceed the number of starters in the dash.

"Day" means a 24-hour period ending at midnight.

"Declaration" means the naming of a particular horse into a particular race.

"Detention barn" means the barn designated for the collection from horses of test samples under the supervision of the commission veterinarian; also, the barn assigned by the commission to a horse on the bleeder list for occupancy as a prerequisite for receiving bleeder medication.

"Driver" means a person licensed to drive in races as a driver.

"Early closing race" means a race for a definite amount, to which entries close at least six weeks preceding the race. The entrance fee may be on the installment plan and no payment shall be refunded.

"Elimination heats" means the individual heats of a race in which the contestants must qualify for a final heat.

"Entry" means a horse made eligible to run in a race; or two or more horses, entered in the same race, which have common ties of ownership, lease, or training. (See also "Coupled entry.")

"Facility" means an entity licensed by the commission to conduct pari-mutuel wagering or gaming operations in Iowa.

"Facility premises" means all real property utilized by the facility in the conduct of its race meeting, including the racetrack, grandstand, concession stands, offices, barns, stables area, employee housing facilities, parking lots, and any other areas under the jurisdiction of the commission.

"Foreign substances" means all substances except those that exist naturally in the untreated horse at normal physiological concentration.

"Futurity" means a stake in which the dam of the competing animal is nominated either when in foal or during the year of foaling.

"Handicap" means a race in which allowance for performance, sex, or distance is made. Post positions for a handicap may be assigned by the racing secretary. Post positions in a handicap claiming race may be determined by claiming price.

"Heat" means a single trial in a race, two in three, or three heat plan.

"Horse" means any equine, including equine designated as a mare, filly, stallion, colt, ridgling or gelding, registered for racing.

"Late closing race" means a race for a fixed amount to which entries close less than six weeks and more than three days before the race is to be contested.

"Licensee" means any person or entity licensed by the commission to engage in racing or related regulated activity.

"Matinee race" means a race in which an entrance fee may be charged and the premiums, if any, are other than money.

"Meeting" means the specified period and dates each year during which a facility is authorized by the commission to conduct pari-mutuel wagering.

"Month" means a calendar month.

"Nomination" means the naming of a horse or, in the event of a futurity, the naming of a foal in utero to a certain race or series of races, when eligibility is conditioned on the payment of a fee at the time of naming and the payment of subsequent sustaining fees or starting fees.

"Nominator" means the person or entity in whose name a horse is nominated for a race or series of races.

"Objection" means a verbal claim of foul in a race lodged by the horse's driver, trainer, owner, or the owner's authorized agent before the race is declared official.

"Optional claiming race" means a contest restricted to horses entered to be claimed for a stated claiming price or to those horses eligible to a specified condition in the case of horses to be claimed in such a race. The race shall be considered, for the purpose of these rules, a claiming race; in the case of horses not entered to be claimed in such a race, the race shall be considered a condition race.

"Overnight race" means a race for which declarations close not more than three days (omitting Sundays) or less than one day before such race is to be contested. In the absence of conditions or notice to the contrary, all entries in overnight events must close not later than 12 noon the day preceding the race.

"Owner" means a person or entity that holds any title, right, or interest, whole or partial, in a horse, including the lessee and lessor of a horse.

"Paddock" means an enclosure in which horses scheduled to compete in a contest are confined prior to racing.

"Post position" means the position behind the starting gate assigned to, drawn by, or earned by a horse.

"Post time" means the scheduled starting time for a contest.

"Race" means a contest between horses for a purse, prize, or other reward contested at a facility in the presence of the stewards of the meeting. Every heat or dash shall be deemed a race for pari-mutuel betting purposes.

"Restricted area" means an area of the facility premises to which access is limited including, but not limited to, a designated area for sample collection, paddock, racetrack, or other area where racing officials carry out the duties of their positions.

"Rules" means the rules promulgated by the commission or U.S.T.A. to regulate the conduct of harness racing. Where a conflict exists between the commission and the U.S.T.A. rules, the commission's rule shall govern.

"Scratch" means the act of withdrawing an entered horse from a contest after the closing of entries.

"Scratch time" means the deadline set by the facility for withdrawal of entries from a scheduled performance.

"Stable name" means a name used, other than the actual legal name of an owner or lessee, and registered with the U.S.T.A. and the commission.

"Stake" means a race that will be contested in a year subsequent to its closing, for which the money given to the facility conducting the same is added to the money contributed by the nominators, all of which, except deductions for the cost of promotion and breeders of nominators awards, belongs to the winner or winners.

"Starter" means a horse that becomes an actual contestant when the word "go" is given by the official starter.

"Steward" means a duly appointed racing official with powers and duties specified by commission rules.

"Subscription" means moneys paid for nomination, entry, eligibility, or starting of a horse in a stakes race.

"U.S.T.A." means the United States Trotting Association.

"Veterinarian" means a veterinarian holding a current unrestricted license issued by the state of Iowa regulatory authority and licensed by the commission.

"Year" means a calendar year.

491—9.2(99D) Facilities' responsibilities.

9.2(1) *Stalls.* The facility shall ensure that racing animals are stabled in individual box stalls; that the stables and immediate surrounding area are maintained in approved sanitary condition at all times; that satisfactory drainage is provided; and that manure and other refuse are kept in separate boxes or containers at locations distant from living quarters and promptly and properly removed.

9.2(2) *Paddocks and equipment.* The facility shall ensure that paddocks, starting gates, and other equipment subject to contact by different animals are kept in a clean condition and free of dangerous surfaces.

9.2(3) *Receiving barn and stalls.* Each facility shall provide a conveniently located receiving barn or stalls for the use of horses arriving during the meeting. The barn shall have adequate stable room and facilities, hot and cold water, and stall bedding. The facility shall employ attendants to operate and maintain the receiving barn or stalls in a clean and healthy condition.

9.2(4) *Fire protection.* The facility shall develop and implement a program for fire prevention on facility premises in accordance with applicable state fire codes. The facility shall instruct employees working on facility premises of procedures for fire prevention and evacuation. The facility shall, in accordance with state fire codes, prohibit the following:

a. Smoking in horse stalls, feed and tack rooms, and in the alleyways.

b. Sleeping in feed rooms or stalls.

c. Open fires, oil- or gasoline-burning lanterns, or lamps in the stable area.

d. Leaving any electrical appliance unattended or in unsafe proximity to walls, beds, or furnishings.

e. Keeping flammable materials, including cleaning fluids or solvents, in the stable area.

f. Locking a stall which is occupied by a horse.

The facility shall post a notice in the stable area which lists the prohibitions outlined in 9.2(4)*"a"* to *"f"* above.

9.2(5) *Starting gate.* During racing hours a facility shall provide at least two operable starting gates that have been approved by the commission.

9.2(6) *Distance markers.*

a. A facility shall provide and maintain starting point markers and distance poles in a size and position that can be clearly seen from the stewards' stand.

b. The starting point markers and distance poles must be marked as follows:

1/4 poles	red and white horizontal stripes
1/8 poles	green and white horizontal stripes
1/16 poles	black and white horizontal stripes

9.2(7) *Detention barn.* Each facility shall maintain a detention barn for use by the commission for securing samples of urine, saliva, blood, or other bodily substances or tissues for chemical analysis from horses who have run in a race. The enclosure shall include a wash rack, commission veterinarian office, a walking ring, at least four stalls, workroom for the sample collectors with hot and cold running water, and glass observation windows for viewing of the horses from the office and workroom. An owner, trainer, or designated representative licensed by the commission shall be with a horse in the detention barn at all times.

9.2(8) *Ambulance.* A facility shall maintain, on the premises during every day that its track is open for racing or exercising, an ambulance for humans and an ambulance for horses, equipped according to prevailing standards and staffed by medical doctors, paramedics, or other personnel trained to operate them. When an ambulance is used for transfer of a horse or patient to medical facilities, a replacement ambulance must be furnished by the facility to comply with this rule.

9.2(9) *Helmets.* A facility shall not allow any person to drive any horse on facility premises unless that person is wearing a protective helmet, of a type approved by the commission, securely fastened under the chin.

9.2(10) *Racetrack.*

a. The surface of a racetrack, including cushion, subsurface, and base, must be designed, constructed, and maintained to provide for the safety of the drivers and racing animals.

b. Distances to be run shall be measured from the starting line at a distance three feet out from the inside rail.

c. A facility shall provide an adequate drainage system for the racetrack.

d. A facility shall provide adequate equipment and personnel to maintain the track surface in a safe training and racing condition. The facility shall provide backup equipment for maintaining the track surface.

e. Rails.

(1) Racetracks shall have inside and outside rails, including gap rails, designed, constructed, and maintained to provide for the safety of drivers and horses. The design and construction of rails must be approved by the commission prior to the first race meeting at the track.

(2) All rails must be constructed of materials designed to withstand the impact of a horse.

9.2(11) *Blacksmith.* During racing hours, each facility shall provide the services of a blacksmith within the paddock.

9.2(12) *Extra equipment.* During racing hours, each facility shall provide suitable extra equipment as may be necessary for the conduct of racing without unnecessary delay.

9.2(13) *Head numbers and saddle pads.* Head numbers and saddle pads must be used on horses when warming up and racing. The saddle pads in use at the facility conducting extended pari-mutuel meetings shall be standardized consistent with a format to be established by U.S.T.A.

9.2(14) *Supervision of meeting.* Although facilities have the obligation of general supervision of their meeting, interference with the proper performance of duties of any official is prohibited.

9.2(15) *Patrol films or video recordings.* Each facility shall provide:

a. A video recording system approved by the commission. Cameras must be located to provide clear panoramic and head-on views of each race. Separate monitors, which simultaneously display the images received from each camera and are capable of simultaneously displaying a synchronized view

of the recordings of each race for review, shall be provided in the stewards' stand. The location and construction of video towers must be approved by the commission.

b. One camera, designated by the commission, to record the prerace of all horses approaching the starting gate and to continue to record until the field is dispatched by the starter.

c. One camera, designated by the commission, to record the apparent winner of each race from the finish line until the horse has returned and the driver has dismounted.

d. At the discretion of the stewards, video camera operators to record the activities of any horses or persons handling horses prior to, during, or following a race.

e. At least three video cameras to record races run on an oval track.

f. Upon request of the commission, without cost, a copy of a video recording of a race.

g. That video recordings recorded prior to, during, and following each race be maintained by the facility for not less than six months after the end of the race meeting, or such other period as may be requested by the stewards or the commission.

h. A viewing room in which, on approval by the stewards, an owner, trainer, driver, or other interested individual may view a video recording of a race.

i. Following any race in which there is an inquiry or objection, the video recorded replays of the incident in question which were utilized by the stewards in making their decision. The facility shall display to the public these video recorded replays on designated monitors.

9.2(16) *Communications.*

a. Each facility shall provide and maintain in good working order a communication system between the:

(1) Stewards' stand;
(2) Racing office;
(3) Tote room;
(4) Drivers' room;
(5) Paddock;
(6) Detention barn;
(7) Starting gate;
(8) Video camera locations;
(9) Clocker's stand;
(10) State racing veterinarian;
(11) Track announcer;
(12) Location of the ambulances (equine and human); and
(13) Other locations and persons designated by the commission.

b. A facility shall provide and maintain a public address system capable of clearly transmitting announcements to the patrons and to the stable area.

9.2(17) *Horsemen's bookkeeper.*

a. General authority. The horsemen's bookkeeper shall maintain the records and accounts and perform the duties described herein and maintain such other records and accounts and perform such other duties as the facility and commission may prescribe.

b. Records.

(1) The records shall include the name, mailing address, social security number or federal tax identification number, and the state or country of residence of each horse owner, trainer, or driver participating at the race meeting who has funds due or on deposit in the horsemen's account.

(2) The records shall include a file of all required statements of partnerships, syndicates, corporations, assignments of interest, lease agreements, and registrations of authorized agents.

(3) All records of the horsemen's bookkeeper shall be kept separate and apart from the records of the facility.

(4) All records of the horsemen's bookkeeper, including records of accounts and moneys and funds kept on deposit, are subject to inspection by the commission at any time.

c. Moneys and funds on account.

(1) All moneys and funds on account with the horsemen's bookkeeper shall be maintained:

1. Separate and apart from moneys and funds of the facility;
2. In a trust account designated as "horsemen's trust account"; and
3. In an account insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation.

(2) The horsemen's bookkeeper shall be bonded.

d. Payment of purses.

(1) The horsemen's bookkeeper shall receive, maintain, and disburse the purse of each race and all stakes, entrance money, driver fees, purchase money in claiming races, all applicable taxes, and other moneys that properly come into the horsemen's bookkeeper's possession in accordance with the provisions of commission rules.

(2) The horsemen's bookkeeper may accept moneys due, belonging to other organizations or recognized meetings, provided prompt return is made to the organization to which the money is due.

(3) The horsemen's bookkeeper shall disburse the purse of each race and all stakes, entrance money, driver fees, purchase money in claiming races, and all applicable taxes, upon request, within 48 hours of receipt of notification that all tests with respect to such races have cleared the drug testing laboratory (commission chemist) as reported by the stewards.

(4) Absent a prior request, the horsemen's bookkeeper shall disburse moneys to the persons entitled to receive same within 15 days after the last race day of the race meeting, including purses for official races, provided that all tests with respect to such races have cleared the drug testing laboratory as reported by the stewards, and provided further that no protest or appeal has been filed with the stewards or the commission.

(5) In the event a protest or appeal has been filed with the stewards or the commission, the horsemen's bookkeeper shall disburse the purse within 48 hours of receipt of dismissal or a final nonappealable order disposing of such protest or appeal.

e. No portion of purse money other than driver fees shall be deducted by the facility for itself or for another, unless so requested in writing by the person to whom purse moneys are payable or the person's duly authorized representative. The horsemen's bookkeeper shall mail to each owner a duplicate of each record of all deposits, withdrawals, or transfers of funds affecting the owner's racing account at the close of each race meeting.

9.2(18) *Timer.* Each facility shall provide for each race an official timer who shall occupy the timer's stand or other appropriate place to observe the contesting of each race. The official timer shall accurately record the time elapsed between the start and finish of each race. The chief timer shall sign the stewards' book for each race verifying the correctness of the record.

491—9.3(99D) Facility policies. It shall be the affirmative responsibility and continuing duty of each occupational licensee to follow and comply with the facility policies as published and distributed by the facility or posted in a conspicuous location.

491—9.4(99D) Racing officials.

9.4(1) *General description.* Every facility conducting a race meeting shall appoint at least the following officials, who shall all have U.S.T.A. certification:

a. One of the members of a three-member board of stewards;
b. Racing secretary;
c. Paddock judge;
d. Horse identifier;
e. Clerk of the course;
f. Official starter;
g. Official charter;
h. Program director;
i. Placing judge;
j. Any other person designated by the commission.

9.4(2) *Officials' prohibited activities.* No racing official or racing official's assistant(s), while serving in that capacity during any meeting, may engage in any of the following:

a. Enter into a business or employment that would be a conflict of interest, interfere with, or conflict with the proper discharge of duties, including a business that does business with a facility or a business issued a concession operator's license;

b. Participate in the sale, purchase, or ownership of any horse racing at the meeting;

c. Sell or solicit horse insurance on any horse racing at the meeting, or any other business sales or solicitation not a part of the official's duties;

d. Wager on the outcome of any race under the jurisdiction of the commission;

e. Accept or receive money or anything of value for the official's assistance in connection with the official's duties;

f. Consume or be under the influence of alcohol or any prohibited substance while performing official duties.

9.4(3) *Single official appointment.* No official appointed to any meeting may hold more than one official position listed in 9.4(1) unless, in the determination of the stewards or commission, the holding of more than one appointment would not subject the official to a conflict of interest or duties in the two appointments.

9.4(4) *Stewards.* (For practice and procedure before the stewards and the commission, see 491—Chapter 4.)

a. General authority.

(1) General. The stewards for each race meeting shall be responsible to the commission for the conduct of the race meeting in accordance with the laws of this state and the rules adopted by the commission. The stewards shall have authority to regulate and to resolve conflicts or disputes between all other racing officials, licensees, and those persons addressed by 491—paragraph 4.6(5)*"e"* which are reasonably related to the conduct of a race or races and to discipline violators of these rules in accordance with the provisions of these rules.

(2) Period of authority. The stewards' authority as set forth in this subrule shall commence 30 days prior to the beginning of each race meeting and shall terminate 30 days after the end of each race meeting or with the completion of their business pertaining to the meeting.

(3) Attendance. All three stewards shall be present in the stand during the running of each race.

(4) Appointment of substitute. Should any steward be absent at race time, the state steward(s) shall appoint a deputy for the absent steward. If any deputy steward is appointed, the commission shall be notified immediately by the stewards.

(5) Initiate action. The stewards shall take notice of questionable conduct or rule violations, with or without complaint, and shall initiate investigations promptly and render a decision on every objection and every complaint made to them.

(6) General enforcement provisions. Stewards shall enforce the laws of Iowa and the rules of the commission. The laws of Iowa and the rules of the commission apply equally during periods of racing. The laws and rules supersede the conditions of a race and the regulations of a race meeting and, in matters pertaining to racing, the orders of the stewards supersede the orders of the officers of the facility. The decision of the stewards as to the extent of a disqualification of any horse in any race shall be final for purposes of distribution of the pari-mutuel pool.

b. Other powers and authority.

(1) The stewards shall have the power to interpret the rules and to decide all questions not specifically covered by the rules.

(2) All questions within the stewards' authority shall be determined by a majority of the stewards.

(3) The stewards shall have control over and access to all areas of the facility premises.

(4) The stewards shall have the authority to determine all questions arising with reference to entries and racing. Persons entering horses to run at a facility agree in so doing to accept the decision of the stewards on any questions relating to a race or racing. The stewards, in their sole discretion, are authorized to determine whether two or more individuals or entities are operating as a single financial

interest or as separate financial interests. In making this determination, the stewards shall consider all relevant information including, but not limited to, the following:

1. Whether the parties pay bills from and deposit receipts in the same accounts.
2. Whether the parties share resources such as employees, feed, supplies, veterinary and farrier services, tack, and equipment.
3. Whether the parties switch horses or owner/trainer for no apparent reason, other than to avoid restrictions of being treated as a single interest.
4. Whether the parties engage in separate racing operations in other jurisdictions.
5. Whether the parties have claimed horses, or transferred claimed horses after the fact, for the other's benefit.
6. If owners, whether one owner is paying the expenses for horses not in the owner's name as owner.
7. If trainers, whether the relationship between the parties is more consistent with that of a trainer and assistant trainer.

(5) The stewards shall have the authority to discipline, for violation of the rules, any person subject to their control and, in their discretion, to impose fines or suspensions, or both, for infractions.

(6) The stewards shall have the authority to order the exclusion or ejection from all premises and enclosures of the facility any person who is disqualified for corrupt practices on any race course in any country.

(7) The stewards shall have the authority to call for proof that a horse is itself not disqualified in any respect, or nominated by, or wholly or in part the property of a disqualified person. In default of proof being given to their satisfaction, the stewards may declare the horse disqualified.

(8) The stewards shall have the authority at any time to order an examination of any horse entered for a race or which has run in a race.

(9) In order to maintain necessary safety and health conditions and to protect the public confidence in horse racing as a sport, the stewards have the authority to authorize a person(s) on their behalf to enter into or upon the buildings, barns, motor vehicles, trailers, or other places within the premises of a facility, to examine same, and to inspect and examine the person, personal property, and effects of any person within such place, and to seize any illegal articles or any items as evidence found.

(10) The stewards shall maintain a log of all infractions of the rules and of all rulings of the stewards upon matters coming before them during the race meet.

(11) The state stewards must give prior approval for any person other than the commissioners or commission representative to be allowed in the stewards' stand.

(12) The stewards shall determine the winner of each race and the order of finish for each of the remaining horses in the race. In case of a difference of opinion among the stewards, the majority opinion shall govern. In determining places at the finish of a race, the stewards shall consider only the noses of the placing horses. The stewards' decision on the race shall be final.

(13) The stewards may correct errors in their determination of the placing of horses at the finish before the display of the official sign or, if the official sign has been displayed in error, after that display. If the display is in error, no person shall be entitled to any proceeds of the pari-mutuel pool on account of the error.

c. Emergency authority.

(1) Substitute officials. When, in an emergency, any official is unable to discharge the official's duties, the stewards may approve the appointment of a substitute and shall report it immediately to the commission.

(2) Substitute driver. The stewards have the authority, in an emergency, to designate a substitute driver for any horse. Before using that authority, the stewards shall in good faith attempt to inform the trainer of the emergency and to afford the trainer the opportunity to appoint a substitute driver. If the trainer cannot be contacted, or if the trainer is contacted but fails to appoint a substitute driver and inform the stewards of the substitution by 30 minutes prior to post time, then the stewards may appoint a substitute driver under this rule.

(3) Substitute trainer. The stewards have the authority in an emergency to designate a substitute trainer for any horse.

(4) Excuse horse. In case of accident or injury to a horse or any other emergency deemed by the stewards before the start of any race, the stewards may excuse the horse from starting.

(5) Exercise authority. No licensee may exercise a horse on the track between races unless upon the approval of the stewards.

(6) Nonstarter. At the discretion of the stewards, any horse(s) precluded from having a fair start may be declared a nonstarter, and any wagers involving said horse(s) may be ordered refunded.

d. Investigations and decisions.

(1) Investigations. The stewards may, upon direction of the commission, conduct inquiries and shall recommend to the commission the issuance of subpoenas to compel the attendance of witnesses and the production of reports, books, papers, and documents for any inquiry. The commission stewards have the power to administer oaths and examine witnesses. The stewards shall submit a written report to the commission of every such inquiry made by them.

(2) Form reversal. The stewards shall take notice of any marked reversal of form by any horse and shall conduct an inquiry of the horse's owner, trainer, or other persons connected with the horse including any person found to have contributed to the deliberate restraint or impediment of a horse in order to cause it not to win or finish as near as possible to first.

(3) Fouls.

1. Extent of disqualification. Upon any claim of foul submitted to them, the stewards shall determine the extent of any disqualification and place any horse found to be disqualified behind others in the race with which it interfered or may place the offending horse last in the race. The stewards, at their discretion, may determine if there was sufficient interference or intimidation to affect the outcome of the race and take the appropriate actions thereafter.

2. Coupled entry. When a horse is disqualified under 9.4(4)*"d"*(3)"1" and that horse was a part of a coupled entry and, in the opinion of the stewards, the act which led to the disqualification served to unduly benefit the other part of the coupled entry, the stewards may disqualify the other part of the entry.

3. Driver guilty of foul. The stewards may discipline any driver whose horse has been disqualified as a result of a foul committed during the running of a race.

(4) Protests and complaints. The stewards shall investigate promptly and render a decision in every protest and complaint made to them. They shall keep a record of all protests and complaints and any rulings made by the stewards and shall file reports daily with the commission.

1. Involving fraud. Protests involving fraud may be made by any person at any time. The protest must be made to the stewards.

2. Not involving fraud. Protests, except those involving fraud, may be filed only by the owner of a horse, authorized agent, trainer, or the driver of the horse in the race about which the protest is made. The protest must be made to the stewards before the race is declared official.

3. Prize money of protested horse. During the time of determination of a protest, any money or prize won by a horse protested or otherwise affected by the outcome of the race shall be paid to and held by the horsemen's bookkeeper until the protest is decided.

4. Protest in writing. A protest, other than one arising out of the actual running of a race, must be in writing, signed by the complainant, and filed with the stewards not later than one hour before post time of the race out of which the protest arises.

5. Frivolous protests. No person shall make a frivolous protest nor may any person withdraw a protest without the permission of the stewards.

9.4(5) *Racing secretary.*

a. General authority. The racing secretary is responsible for setting the conditions for each race of the meeting, regulating the nomination of entries, determining the amounts of purses and to whom they are due, and the recording of racing results. The racing secretary shall permit no person other than licensed racing officials to enter the racing secretary's office or work areas until such time as all entries are closed, drawn, and smoked. Exceptions to this rule must be approved by the stewards.

b. Conditions. The racing secretary shall establish the conditions and eligibility for entering the races of the meeting and cause them to be published to owners, trainers, and the commission. Corrections to the conditions must be made within 24 hours of publication.

c. Posting of entries. Upon the completion of the draw each day, the racing secretary shall post a list of entries in a conspicuous location in the racing office and make the list available to the public.

d. Stakes and entrance money records. The racing secretary shall be caretaker of the permanent records of all stakes, entrance moneys, and arrears paid or due in a race meeting and shall keep permanent records of the results of each race of the meeting.

e. Winnings—all inclusive. For the purpose of the setting of conditions by the racing secretary, winnings shall be considered to include all moneys and bonus awards won up to the time when entries close, but winnings on the closing date of eligibility shall not be considered.

f. Cancellation of a race. The racing secretary has the authority to withdraw, cancel, or change any race which has not been closed. In the event the canceled race is a stakes race, all subscriptions and fees paid in connection with the race shall be refunded.

g. Coggins test or equine infectious anemia. The racing secretary shall ensure that all horses have a current negative Coggins test or negative equine infectious anemia test. The racing secretary shall report all expired certificates to the stewards.

h. Rejection of declaration.

(1) The racing secretary may reject the declaration of any horse whose eligibility certificate or electronic eligibility certificate was not in the possession of the racing secretary on the date the condition book was published.

(2) The racing secretary may reject the declaration of any horse whose past performance indicates that the horse would be below the competitive level of other horses declared, provided the rejection does not result in a race's being canceled.

i. Eligibility certificate or electronic eligibility certificates. The racing secretary will receive and keep the eligibility certificate or electronic eligibility certificate of horses competing at the facility and return same to the owner or the owner's representative upon request.

j. Declaration blanks. The racing secretary will examine all declaration blanks to verify all information set forth therein.

k. Verification of eligibility. The racing secretary will check the eligibility of all horses drawn in to race and verify the horses' eligibility with the stewards.

l. Registration. The racing secretary shall be responsible for the care and security of all registrations and supporting documents submitted by the trainers while the horses are located on facility premises. Disclosure is made for the benefit of the public, and all documents pertaining to the ownership or lease of a horse filed with the racing secretary shall be available for public inspection.

m. Certificates. Rescinded IAB 10/17/01, effective 11/21/01.

9.4(6) *Paddock judge.*

a. General authority. The paddock judge shall:

(1) Be in charge of the paddock and shall have general responsibility for the inspection of horses and for the equipment used.

(2) Attempt to maintain consistency in the use of equipment on individual horses.

(3) Supervise paddock gate men.

b. Duties. The paddock judge shall:

(1) Ensure that only properly authorized persons are permitted in the paddock.

(2) Get the fields on the racetrack for post parades.

(3) Properly check in and check out horses and drivers.

(4) Immediately notify the stewards of anything that could in any way change, delay, or otherwise affect the racing program.

(5) Report to stewards any observed cruelty to a horse.

9.4(7) *Horse identifier.*

a. General authority. The horse identifier shall be present for each race. The identifier shall inspect the horse's tattoo number or freeze brand number, color, and any markings prior to the horse's departure from the paddock to post to ensure it is the appropriate horse.

b. Report violations. Any discrepancy detected in the tattoo number or freeze brand number, color or markings of a horse shall be reported immediately to the paddock judge, who shall in turn report same forthwith to the stewards.

9.4(8) *Clerk of the course.* The clerk of the course shall be responsible for keeping and verifying the stewards' book, eligibility certificates or electronic eligibility certificates provided by the U.S.T.A. or C.T.A. and shall:

a. Record therein the following information:

(1) Names and addresses of owners;

(2) The standard symbols for medications, where applicable;

(3) Notations of placing, disqualifications, and claimed horses; and

(4) Notations of scratched or ruled out horses.

b. Rescinded IAB 5/10/06, effective 6/14/06.

c. Notify owners and drivers of penalties assessed by the official.

d. Assist in drawing post positions, if requested.

e. Maintain the stewards' list.

9.4(9) *Starter.*

a. General authority. The starter is responsible for providing a fair start for each race.

b. Disciplinary action. The official starter may recommend to the stewards fines or suspension of the licenses of drivers for any violations of these rules from the formation of the parade until the word "go" is given.

c. Starter's list. The official starter shall school horses as may be necessary and shall prepare a list of horses not qualified to start, which shall be delivered to the stewards and the racing secretary and entered on the starter's list. The starter's list shall be posted in the racing secretary's office. No horse on the starter's list shall be eligible to declare until removed from the list.

9.4(10) *Official charter.* The charting of races is mandatory and the facility shall employ a licensed charter from the U.S.T.A.

9.4(11) *Commission veterinarians (veterinarian).*

a. The veterinarian(s) shall advise the commission and the stewards on all veterinary matters.

b. The veterinarian(s) shall have supervision and control of the detention barn for the collection of test samples for the testing of horses for prohibited medication as provided in Iowa Code sections 99D.23(2) and 99D.25(9). The commission may employ persons to assist the veterinarian(s) in maintaining the detention barn area and collecting test samples.

c. The veterinarian(s) shall not buy or sell any horse under the veterinarian's supervision; wager on a race under the veterinarian's supervision; or be licensed to participate in racing in any other capacity.

d. The veterinarian(s) may request that any horse entered in a race undergo an examination on the day of the race to determine the general fitness of the horse for racing. During the examination, all bandages shall be removed by the groom upon request and the horse may be exercised outside the stall to permit the examiner to determine the condition of the horse's legs and feet. The examining veterinarian shall report any unsoundness in a horse to the stewards.

e. A veterinarian shall inspect all of the horses in a race in the paddock, during the post parade and scoring prior to the start, and shall observe the horses upon their leaving the track after the finish of a race.

f. The veterinarian shall place any horse determined to be sick or too unsafe, unsound, or unfit to race on a veterinarian's list that shall be posted in a conspicuous place available to all owners, trainers, and officials.

g. A horse placed on the veterinarian's list, bleeders exempt, may be allowed to enter only after it has been removed from the list by the commission veterinarian. Requests for the removal of any horse from the veterinarian's list will be accepted only after three calendar days have elapsed from the placing

of the horse on the veterinarian's list. Removal from the list will be at the discretion of the commission veterinarian who may require satisfactory workouts or examinations to adequately demonstrate that the problem that caused the horse to be placed on the list has been rectified. Horses that are entered to race and then placed on the veterinarian's list for any reason will not be allowed to enter a race for a minimum of three calendar days beginning the day after the horse was scheduled to race.

Every confirmed bleeder, regardless of age, shall be placed on the bleeder list and shall be ineligible to race for the following time periods:

(1) First incident – 14 days.

(2) Second incident within 365-day period – 30 days.

(3) Third incident within 365-day period – 180 days.

(4) Fourth incident within 365-day period – barred for racing lifetime.

For the purposes of counting the number of days a horse is ineligible to run, the day the horse bled externally is the first day of the recovery period. The voluntary administration of furosemide without an external bleeding incident shall not subject the horse to the initial period of ineligibility specified in subparagraph (1). A horse may be removed from the bleeder list only upon the direction of the official veterinarian who shall certify in writing to the stewards the recommendation for removal. A horse which has been placed on a bleeder list in another jurisdiction pursuant to these rules shall be placed on a bleeder list in this jurisdiction.

h. The veterinarian(s) shall supervise and ensure that the administration of furosemide and phenylbutazone is in compliance with Iowa Code section 99D.25A.

i. Rescinded IAB 9/29/04, effective 11/3/04.

j. The veterinarian(s) or commission representative shall take receipt of veterinary reports as required by Iowa Code section 99D.25(10).

9.4(12) *Driver room custodian.* The driver room custodian shall have the following duties:

a. Maintain order, decorum and cleanliness in the driver's room.

b. Ensure that no person other than representatives of the commission, representatives of the facility, and drivers are admitted to the driver's room on a racing day except by permission of the stewards and ensure that no unauthorized personnel are permitted in the driver's room after the final race on racing days.

c. Ensure that drivers are neat in appearance and properly attired when they leave the driver's room to drive in a race.

d. Report any rule violations within the driver's room to stewards.

e. Assign to each driver a locker for the use of the driver in storing clothing, equipment and personal effects.

9.4(13) *Mutuel manager.* The mutuel manager is responsible for the operation of the mutuel department. The mutuel manager shall ensure that any delays in the running of official races caused by totalizator malfunctions are reported to the stewards. The mutuel manager shall submit a written report on any delay when requested by the state steward.

491—9.5(99D) Trainer and driver responsibilities.

9.5(1) *Trainer.*

a. Responsibility. The trainer is responsible for:

(1) The condition of horses entered in any race and, in the absence of substantial evidence to the contrary, for the presence of any prohibited drug, medication, or other substance, including permitted medication in excess of the maximum allowable level, in such horses, regardless of the acts of third parties. A positive test for a prohibited drug, medication, or substance, including permitted medication in excess of the maximum allowable level, as reported by a commission-approved laboratory, is prima facie evidence of a violation of this rule or Iowa Code chapter 99D.

(2) Preventing the administration of any drug, medication, or other prohibited substance that may cause a violation of these rules.

(3) Any violation of rules regarding a claimed horse's participation in the race in which the trainer's horse is claimed.

(4) The condition and contents of stalls, tack rooms, feed rooms, sleeping rooms, and other areas which have been assigned to the trainer by the facility, and maintaining the assigned stable area in a clean, neat, and sanitary condition at all times.

(5) Ensuring that fire prevention rules are strictly observed in the assigned stable area.

(6) Being present to witness the administration of furosemide during the administration time and sign as the witness on the affidavit form. A licensed designee of the trainer may witness the administration of the furosemide and sign as the witness on the affidavit form; however, this designee may not be another practicing veterinarian or veterinary assistant.

(7) The proper identity, custody, care, health, condition, and safety of horses in the trainer's charge.

(8) Disclosure to the racing secretary of the true and entire ownership of each horse in the trainer's care, custody, or control. Any change in ownership shall be, subject to approval of the stewards, reported immediately to and recorded by the racing secretary. The disclosure, together with all written agreements and affidavits setting out oral agreements pertaining to the ownership for or rights in and to a horse, shall be attached to the registration certificate for the horse and filed with the racing secretary.

(9) Training all horses owned wholly or in part by the trainer which are participating at the race meeting, unless otherwise approved by the stewards.

(10) Registering with the racing secretary each horse in the trainer's charge within 24 hours of the horse's arrival on facility premises.

(11) Ensuring that, at the time of arrival at the facility, each horse in the trainer's care is accompanied by a valid health certificate and evidence of a negative Coggins test, which shall be filed with the racing secretary.

(12) Having each horse in the trainer's care that is racing or stabled on facility premises tested for equine infectious anemia (EIA) in accordance with state law and for filing evidence of such negative test results with the racing secretary. The test must have been conducted within the previous 12 months and must be repeated upon expiration. The certificate must be attached to the eligibility certificate or on file with the racing secretary.

(13) Using the services of those veterinarians licensed by the commission to attend horses that are on facility premises.

(14) Immediately reporting the alteration of the sex of a horse in the trainer's care to the horse identifier and the racing secretary.

(15) Promptly reporting to the racing secretary and the commission veterinarian any horse on which a posterior digital neurectomy (heel nerving) has been performed and ensuring that such fact is designated on its certificate of registration or on file with the state veterinarian's office. See Iowa Code subsections 99D.25(1) to 99D.25(3).

(16) Promptly reporting to the stewards and the commission veterinarian the serious illness of any horse in the trainer's charge.

(17) Promptly reporting the death of any horse on facility premises in the trainer's care to the stewards, owner, and the commission veterinarian and complying with Iowa Code subsection 99D.25(5) governing postmortem examination.

(18) Maintaining a knowledge of the medication record and status of all horses in the trainer's care.

(19) Immediately reporting to the stewards and the commission veterinarian if the trainer knows, or has cause to believe, that a horse in the trainer's custody, care, or control has received any prohibited drugs or medication.

(20) Representing an owner in making entries and scratches and in all other matters pertaining to racing.

(21) Ensuring the eligibility of horses entered and allowances claimed.

(22) Ensuring the fitness of a horse to perform creditably at the distance entered.

(23) Ensuring that the trainer's horses are properly shod, bandaged, and equipped.

(24) Presenting the trainer's horse in the paddock at least one hour before post time or at a time otherwise appointed before the race in which the horse is entered.

(25) Personally attending to the trainer's horses in the paddock and supervising the harnessing thereof, unless excused by the stewards.

(26) Instructing the driver to give the driver's best effort during a race and instructing the driver that each horse shall be driven to win.

(27) Witnessing the collection of a urine or blood sample from the horse in the trainer's charge or delegating a licensed employee or the owner of the horse to do so.

(28) Notifying horse owners upon the revocation or suspension of the trainer's license. Upon application by the owner, the stewards may approve the transfer of such horses to the care of another licensed trainer and, upon such approved transfer, such horses may be entered to race.

(29) Securing the services of a driver prior to making a declaration.

b. Restrictions on wagering. A trainer with a horse(s) entered in a race shall be allowed to wager only on that horse(s) or that horse(s) in combination with other horses.

c. Assistant trainers.

(1) Upon the demonstration of a valid need, a trainer may employ an assistant trainer as approved by the stewards. The assistant trainer shall be licensed prior to acting in such capacity on behalf of the trainer.

(2) Qualifications for obtaining an assistant trainer's license shall be prescribed by the stewards and the commission and may include requirements set forth in 491—Chapter 6.

(3) An assistant trainer may substitute for and shall assume the same duties, responsibilities, and restrictions as are imposed on the licensed trainer. In such case, the trainer shall be jointly responsible for the assistant trainer's compliance with the rules.

d. Substitute trainers.

(1) A trainer absent for more than five days from responsibility as a licensed trainer, or on a day in which the trainer has a horse in a race, shall obtain another licensed trainer to substitute.

(2) A substitute trainer shall accept responsibility for the horses in writing and shall be approved by the stewards.

(3) A substitute trainer and the absent trainer shall be jointly responsible as absolute ensurers of the condition of their horses entered in an official workout or race.

9.5(2) *Driver.*

a. Driving duty. Every driver shall participate when programmed unless excused by the stewards. A driver shall give a best effort during a race and each horse shall be driven to win.

b. Driving colors. Drivers must wear distinguishing colors and clean white pants and shall not be allowed to start in a race unless, in the opinion of the stewards, they are properly dressed. No person shall drive a horse during the time when colors are required on the racetrack unless the person is wearing a protective helmet, painted as registered or of compatible colors, and has a chin strap in place.

c. Driver betting. No driver shall bet, or cause any other person to bet on the driver's behalf, on any other horse in any race in which the driver shall start a horse driven by the driver. No such person shall participate in exacta, quinella, or other multiple-pool wagering on a race in which such horse starts other than the daily double.

d. Fine, suspension or both. A fine, suspension or both may be applied to any driver for:

(1) Delaying the start;

(2) Failure to obey the starter's instructions;

(3) Rushing ahead of the inside or outside wing of the gate;

(4) Coming to the starting gate out of position;

(5) Crossing over before reaching the starting point;

(6) Interference with another horse or driver during the start or during the running of the race; or

(7) Failure to come up into position and remain in position.

491—9.6(99D) Conduct of races.

9.6(1) *Horses ineligible.* Any horse ineligible to be entered for a race, or ineligible to start in any race, that competes in that race may be disqualified and the stewards may discipline the persons responsible for that horse competing in that race. A horse is ineligible to start a race when:

a. The horse is not stabled on the premises of the licensed facility by the time so designated by the stewards;

b. The U.S.T.A. or C.T.A. eligibility certificate or electronic eligibility certificate has not been examined by the racing secretary, or horse identifier, and determined to be proper and in order;

c. The horse is not fully identified by an official tattoo on the inside of the upper lip or a freeze brand applied by an authorized U.S.T.A. or C.T.A. technician;

d. With respect to a horse that is entered for the first time, the nominator has failed to identify the horse by name, color, sex, age, names of sire and dam as registered, and present owner and trainer;

e. The horse is brought to the paddock and is not in the care of and harnessed by a licensed trainer or assistant trainer;

f. The horse has been knowingly entered or raced in any jurisdiction under a different name, with an altered eligibility certificate or electronic eligibility certificate, or altered lip tattoo by a person having lawful custody or control of the horse for the purpose of deceiving any facility or regulatory agency;

g. The horse has been allowed to enter or start by a person having lawful custody or control of the horse who participated in or assisted in the entry of racing of some other horse under the name of the horse in question;

h. The horse is wholly or partially owned by a disqualified person or is under the direct or indirect management of a disqualified person;

i. The horse is wholly or partially owned by the spouse of a disqualified person or is under the direct or indirect management of the spouse of a disqualified person; in such cases, it is presumed that the disqualified person and spouse constitute a single financial entry with respect to the horse, which presumption may be rebutted;

j. The horse has no current negative Coggins test certificate or negative equine infectious anemia test certificate attached to the eligibility certificate or on file with the racing secretary;

k. The stakes or entrance money for the horse has not been paid;

l. The horse appears on the starter's list, stewards' list, or veterinarian's list;

m. The horse is a first-time starter not meeting qualifications standards for the race meeting;

n. The horse is owned in whole or in part by an undisclosed person of interest;

o. The horse is subject to a lien that has not been approved by the stewards and filed with the horsemen's bookkeeper;

p. The horse is subject to a lease not filed with the stewards;

q. The horse is not in sound racing condition;

r. The horse has been nerved by surgical neurectomy;

s. The horse has been trachea-tubed to artificially assist breathing;

t. The horse has been blocked with alcohol or injected with any other foreign substance or drug to desensitize the nerves of the leg;

u. The horse has impaired eyesight in both eyes;

v. The horse appears on the starter's list, stewards' list, or veterinarian's list of any racing jurisdiction or is barred from racing in any racing jurisdiction; or

w. The horse has started in any race on the previous calendar day.

9.6(2) *Two-year-old horses.* No two-year-old horse shall be permitted to start in a dash or heat exceeding one mile in distance, and no two-year-old shall be permitted to race in more than two heats or dashes in any single day.

9.6(3) *Registration.* All matters relating to registration of standardbred horses shall be governed by the rules of the U.S.T.A.

9.6(4) *Eligibility certificate or electronic eligibility certificate.* A facility may refuse to accept any declaration without the eligibility certificate or electronic eligibility certificate for the proper gait first being presented. Fax or telephone declarations may be sent and accepted without penalty, provided the declarer furnished adequate program information, but the eligibility certificate or electronic eligibility certificate must be presented when the horse arrives at the facility and before it races. The racing secretary shall check each certificate and certify to the stewards as to the eligibility of all the horses.

9.6(5) *Canadian track information.* Prior to the declaration, owners of horses having Canadian certificates shall furnish the racing secretary with a Canadian certificate completely filled out for the current year, which has a U.S.T.A. validation certificate attached.

9.6(6) *Foreign entries.* No eligibility certificate or electronic eligibility certificate will be issued on a horse coming from a country other than Canada unless the following information, certified by the trotting association or governing body of that country from which the horse comes, is furnished:

a. The number of starts during the preceding year, together with the number of firsts, seconds, and thirds for the horse, and the total amount of money won during the current period.

b. The number of races in which the horse has started during the preceding year, together with the number of firsts, seconds, and thirds for the horse, and the total amount of money won during the current period.

c. A detailed list of the last six starts giving the date, place, track condition, post position or handicap, if it was a handicap race, distance of the race, position at the finish, the time of the race, the driver's name, and the first three horses in the race.

9.6(7) *Time bars.* No time records or bars shall be used as an element of eligibility.

9.6(8) *Date when eligibility is determined.*

a. Horses must be eligible when entries close but winnings on the closing date of eligibility shall not be considered.

b. In mixed races, trotting and pacing, a horse must be eligible to the class at the gait at which it is stated in the entry the horse will perform.

9.6(9) *Conflicting conditions.* In the event there are conflicting published conditions and neither is withdrawn by the facility, the more favorable to the nominator shall govern.

9.6(10) *Overnight events.*

a. Standards for overnight events. When time standards are established at a meeting for both trotters and pacers, trotters shall be given a minimum of two seconds allowance in relation to pacers.

b. Posting of overnight conditions. At extended pari-mutuel meetings, condition books will be prepared and races may be divided or substituted only when regularly scheduled races fail to fill. Books containing at least three days' racing programs will be available to horsemen at least 24 hours prior to closing declarations on any race program contained. When published, the conditions must be clearly stated and not printed as TBA—To Be Announced. The racing secretary shall forward copies of each condition book and overnight sheet to the commission and U.S.T.A. office as soon as they are available to the horsemen.

9.6(11) *Supplemental purse payments.* Supplemental purse payments made by a track after the termination of a meeting will be charged and credited to the winnings of any horse at the end of the racing year in which they are distributed and will appear on the eligibility certificate or electronic eligibility certificate for the subsequent year. Distribution shall not affect the current eligibility until placed on the next eligibility certificate or electronic eligibility certificate.

9.6(12) *Substitute and divided races.*

a. Substitute races may be provided for each day's program and shall be so designated. Entries in races not filling shall be posted. A substitute race or a race divided into two divisions shall be used only if regularly scheduled races fail to fill.

b. If a regular race fills, it shall be raced on the day it was offered.

c. Overnight events and substitutes shall not be carried over to the next racing day.

9.6(13) *Qualifying races.* A horse qualifying in a qualifying race for which no purse is offered shall not be deprived by reason of that performance of the right to start in any conditioned race.

9.6(14) *Start.* The definition of the word "start" in any type of condition unless specifically so stated will include only those performances in a purse race. Qualifying and matinee races are excluded.

9.6(15) *Claiming races.*

a. Eligibility.

(1) No person may file a claim for any horse unless the person:

1. Is a licensed owner at the meeting who has started a horse at the meeting; or

2. Is a licensed authorized agent, authorized to claim for an owner eligible to claim; or

3. Has a valid open claim certificate. Any person not licensed as an owner, or a licensed authorized agent for the account of the same, or a licensed owner who has not started a horse at the meeting may request an open claim certificate from the commission. The person must submit a completed application

for a prospective owner's license to the commission. The applicant must give the name of the trainer licensed by the commission who will be responsible for the claimed horse. A nonrefundable fee must accompany the application along with any financial information requested by the commission. The names of the prospective owners shall be prominently displayed in the offices of the commission and the racing secretary. The application will be processed by the commission and when the open claim certificate is exercised, an owner's license will be issued.

(2) One stable claim. No stable that consists of horses owned by more than one person and which has a single trainer may submit more than one claim in any race. An authorized agent may submit only one claim in any race regardless of the number of owners represented.

b. Procedure for claiming. To make a claim for a horse, an eligible person shall:

(1) Deposit to the person's account with the horsemen's bookkeeper the full claiming price and applicable taxes as established by the racing secretary's conditions.

(2) File in a locked claim box, maintained for that purpose by the stewards or their designee, a claim filled out completely in writing and with sufficient accuracy to identify the claim on forms provided by the facility at least ten minutes before the time of the race.

c. Claim box.

(1) The claim box shall be approved by the commission and kept locked until ten minutes prior to the start of the race when it shall be presented to the stewards or their representative for opening and publication of the claims.

(2) The claim box shall include a time clock which automatically stamps the time on the claim envelope prior to its being dropped in the box.

(3) No official of a facility shall give any information as to the filing of claims therein until after the race has been run.

d. Claim irrevocable. After a claim has been filed in the claim box, it shall not be withdrawn.

e. Multiple claims on single horses. If more than one claim is filed on a horse, the successful claim shall be determined by lot conducted by the stewards or their representatives.

f. Successful claims; later races.

(1) Sale or transfer. No successful claimant may sell or transfer a horse, except in a claiming race, for a period of 30 days from the date of claim.

(2) Eligibility price. A horse that is declared the official winner in the race in which it is claimed may not start in a race in which the claiming price is less than the amount for which it was claimed. After the first start back or 30 days, whichever occurs first, a horse may start for any claiming price. A horse which is not the official winner in the race in which it is claimed may start for any claiming price. No right, title, or interest for any claimed horse shall be sold or transferred except in a claiming race for a period of 30 days following the date of claiming. The day claimed shall not count, but the following calendar day shall be the first day.

(3) Racing elsewhere. A horse that was claimed under these rules may not participate at a race meeting other than that at which it was claimed until the end of the meeting, except with written permission of the stewards. This limitation shall not apply to stakes races.

(4) Same management. A claimed horse shall not remain in the same stable or under the control or management of its former owner.

(5) When a horse is claimed out of a claiming race, the horse's engagements are included.

g. Transfer after claim.

(1) Forms. Upon a successful claim, the stewards shall issue in triplicate, upon forms approved by the commission, an authorization of transfer of the horse from the original owner to the claimant. Copies of the transfer authorization shall be forwarded to and maintained by the commission, the stewards, and the racing secretary. No claimed horse shall be delivered by the original owner to the successful claimant until authorized by the stewards. Every horse claimed shall race for the account of the original owner, but title to the horse shall be transferred to the claimant from the time the horse becomes a starter. The successful claimant shall become the owner of the horse at the time of starting, regardless of whether it is alive or dead, sound or unsound, or injured during or after the race. The original trainer of the claimed horse shall be responsible for the postrace test results.

(2) Other jurisdiction rules. The commission will recognize and be governed by the rules of any other jurisdiction regulating title and claiming races when ownership of a horse is transferred or affected by a claiming race conducted in that other jurisdiction.

(3) Determination of sex and age. The claimant shall be responsible for determining the age and sex of the horse claimed notwithstanding any designation of sex and age appearing in the program or in any racing publication. In the event of a spayed mare, the (s) for spayed should appear next to the mare's name on the program. If it does not, and the claimant finds that the mare is in fact spayed, claimant may then return the mare for full refund of the claiming price.

(4) Affidavit by claimant. The stewards may, if they determine it necessary, require any claimant to execute a sworn statement that the claimant is claiming the horse for the claimant's own account or as an authorized agent for a principal and not for any other person.

(5) Delivery required. No person shall refuse to deliver a properly claimed horse to the successful claimant. The claimed horse shall be disqualified from entering any race until delivery is made to the claimant.

(6) Obstructing rules of claiming. No person or licensee shall obstruct or interfere with another person or licensee in claiming any horse, enter into any agreement with another to subvert or defeat the object and procedures of a claiming race, or attempt to prevent any horse entered from being claimed.

h. Elimination of stable. An owner whose stable has been eliminated by claiming may claim for the remainder of the meeting at which eliminated or for 30 racing days, whichever is longer. With the permission of the stewards, stables eliminated by fire or other casualty may claim under this rule.

i. Deceptive claim. The stewards may cancel and disallow any claim within 24 hours after a race if they determine that a claim was made upon the basis of a lease, sale, or entry of a horse made for the purpose of fraudulently obtaining the privilege of making a claim. In the event of a disallowance, the stewards may further order the return of a horse to its original owner and the return of all claim moneys.

j. Protest of claim. A protest to any claim must be filed with the stewards before noon of the day following the date of the race in which the horse was claimed. Nonracing days are excluded from this rule.

9.6(16) *Entries.* All entries must:

a. Be made in writing.

b. Be signed by the owner or authorized agent, except as provided in this chapter.

c. Give name and address of the owner and agent or registered stable name or lessee.

d. Give name, color, sex, sire, and dam of horse.

e. Name the event or events in which the horse is to be entered.

9.6(17) *Entries and starters; split races.*

a. Entries required. The facility must specify how many entries are required for overnight events and, after the condition is fulfilled, the event must be contested.

b. Elimination heats or two divisions. In any race where the number of horses declared to start exceeds 11 on a half-mile track, or 14 on a larger track, unless lesser numbers are specified in the conditions of the race, the race, at the option of the facility and stated before positions are drawn, may be raced in elimination heats.

In the absence of conditions providing for a lesser number of starters, no more than two tiers of horses, allowing eight feet per horse, will be allowed to start in any race.

c. Elimination plans.

(1) Whenever elimination heats are required, or specified in the published conditions, the race shall be raced in the following manner unless otherwise stated in the conditions or conducted under another segment of these rules. The field shall be divided by lot and the first division shall race a qualifying dash for 30 percent of the purse, the second division shall race a qualifying dash for 30 percent of the purse, and the horses so qualified shall race in the main event for 40 percent of the purse. The winner of the main event shall be the race winner.

(2) In the event there are more horses declared to start than can be accommodated by the two elimination dashes, there shall be added enough elimination dashes to take care of the excess. The percent

of the purse raced for each elimination dash will be determined by dividing the number of elimination dashes into 60. The main event will race for 40 percent of the purse.

1. Draw positions to determine which of the dash winners has the pole and which the second position; which of the two horses that have been second shall start in third position and which in fourth; and subsequent positions, or

2. Have an open draw to determine the positions in which the horses are to start in the main event; that is, all positions shall be drawn by lot from among all horses qualified for the main event. In the event the sponsor fails to prescribe in the conditions for the event the method to be used for the drawing of post positions, the provisions of paragraph "1" above shall apply.

d. Overnight events. In overnight events at extended pari-mutuel meetings, not more than eight horses shall be allowed to start on a half-mile track and not more than ten horses on larger tracks.

e. Qualifying race for stake. Where qualifying races are provided in the conditions of any early closing event, stakes, or futurity, the qualifying race must be held not more than seven days prior to contesting the main event, omitting the day of the race.

9.6(18) *Declaration to start; drawing horses.*

a. Declaration.

(1) Declaration time shall be determined by the stewards.

(2) No horse shall be declared to start in more than one race on any one racing day.

(3) Declaration box (box). The facility shall provide a locked box with an aperture through which declarations shall be deposited.

(4) Responsibility for box. The stewards shall be in charge of the box.

(5) Search for declarations by the steward(s) before opening box. Just prior to opening of the box at extended pari-mutuel meetings where futurities, stakes, early closing, or late closing events are on the program, the steward(s) shall check with the racing secretary to ascertain if any declarations by mail, fax, or otherwise are in the office and not deposited in the box and shall see that they are declared and drawn in the proper event.

(6) Opening of box. The box shall be opened by the steward(s) at the advertised time and the steward(s) will be responsible for ensuring that at least one horseman or the horseman's official representative is present. No owner or agent for a horse with a declaration in the box shall be denied the privilege of being present. Under the supervision of the steward(s), all declarations shall be listed, the eligibility verified, the preference ascertained, starters selected, and post positions drawn. If it is necessary to reopen any race, public announcement shall be made at least twice and the box reopened at a defined time.

(7) Drawing of post positions for heats in races of more than one dash or heat. In races of a duration of more than one dash or heat, the stewards may draw post positions from the stand for succeeding dashes or heats.

(8) Declarations by mail, fax, or telephone. Declarations by mail, fax, or telephone actually received and evidence of which is deposited in the box before the time specified to declare shall be drawn in the same manner as the others. Drawings shall be final. Mail, fax, and telephone declarations must state the name and address of the owner or lessee; the name, color, sex, sire and dam of the horse; the name of the driver and colors; the date and place of last start; a current summary, including the number of starts, firsts, seconds, thirds, earnings, and best winning time for the current year; and the event or events in which the horse is to be entered.

(9) Effect of failure to declare on time. When a facility requires a horse to be declared by a stated time, failure to declare as required shall be considered a withdrawal from the event.

(10) Drawings of horses after declaration. After declaration to start has been made, no horse shall be drawn except by permission of the stewards.

(11) Horses omitted through error. Drawings shall be final unless there is conclusive evidence that a horse properly declared was omitted from the race through the error of the facility or its agent or employee, in which event the horse shall be added to the race but given the last post position, provided the error is discovered prior to scratch time or the printing of the program, whichever is sooner. However, in the case of early closers and stake and futurity races, the race shall be redrawn.

b. Qualifying races. At all extended pari-mutuel meetings, eligibility to declare for overnight events shall be governed by the following:

(1) Within 30 days of being declared in, a horse that has not raced previously at the gait chosen must go through a qualifying race under the supervision of a steward and acquire at least one charted line by a licensed charter. In order to provide complete and accurate chart information on time and beaten lengths, a standard photo finish shall be in use.

(2) A horse that does not show a charted line for the previous season or a charted line within its last six starts must go through a qualifying race as set forth above. Uncharted races contested in heats of more than one dash and consolidated according to subparagraph 9.6(18)*"b"*(4) below will be considered one start.

(3) A horse that has not started at a charted meeting by April 1 of a season must go through a qualifying race and meet the qualifying standards of the meet.

(4) When a horse has raced at a charted meeting during the current season, then gone to meetings where the races are not charted, the information from the uncharted races may be summarized, including each start, and consolidated in favor of charted lines. The requirements of subparagraph 9.6(18)*"b"*(2) above would not then apply.

(5) The consolidated line shall carry date, place, time, driver, finish, track condition, and distance if race is not at one mile.

(6) The stewards may require any horse that has been on the stewards' list to go through a qualifying race. A horse that is on the stewards' list for breaks or refusing to come to the gate must qualify in a qualifying race.

(7) If a horse has not raced an individual time meeting the qualifying standards for that class of horse, the horse may be required to go through a qualifying race.

(8) The stewards may permit a fast horse to qualify by means of a timed workout consistent with the time of the races in which it will compete in the event adequate competition is not available for a qualifying race.

(9) To enable a horse to qualify, qualifying races should be held at least one full week prior to the opening of any meeting and shall be scheduled once a week during the meeting and through the last week of the meeting.

(10) When a race is conducted for the purpose of qualifying drivers and not horses, the race need not be charted, timed, or recorded. This subparagraph is not applicable to races qualifying both drivers and horses.

(11) If a horse takes a win race record in a qualifying race, the record must be prefaced with the letter "Q" wherever it appears, except in a case where, immediately prior to or following the race, the horse taking the record has had a specimen taken and tested. It will be the responsibility of the steward to report the results of the test on the stewards' sheet.

(12) Any horse that fails to race at a charted meeting within 30 days after having started in a current year shall start in a charted race or a qualifying race and meet the standards of the meeting before being allowed to start.

c. Coupled entries.

(1) When one owner or lessee enters more than one horse in the same race, the horses shall be coupled as an entry. Horses shall be regarded as having a common owner when an owner of one horse, either as an individual, a licensed member of a partnership, or a licensed shareholder of a corporation, has an aggregate commonality of ownership of 5 percent interest in another horse, either as an individual, a licensed member of a partnership, or a licensed shareholder of a corporation. If the race is split in two or more divisions, horses in an "entry" shall be seeded insofar as possible, first by owners, then by trainer, then by stables; but the divisions in which the horses compete and their post positions shall be drawn by lot. The above provision shall also apply to elimination heats.

(2) Coupled entry limitations on owner. No more than two horses coupled by a common ownership or trainer shall be entered in an overnight race.

(3) Coupling entries by stewards. The stewards shall couple as a single entry any horses which, in the determination of the stewards, are connected by common ownership, common lessee, or when the

stewards determine that coupling is necessary in the interest of the regulation of a pari-mutuel wagering industry or is necessary to ensure the public's confidence in racing.

d. Also eligibles. No more than two horses may be drawn as also eligibles for a race and their positions shall be drawn along with the starters in the race. In the event one or more horses are excused by the stewards, the also eligible horse(s) shall race and take the post position drawn by the horse that it replaces, except in handicap races. In handicap races the also eligible horse shall take the place of the horse that it replaces in the event that the handicap is the same. In the event the handicap is different, the also eligible horse shall take the position on the outside of horses with a similar handicap. No horse may be added to a race as an also eligible unless the horse was drawn as such at the time declarations closed. No horse may be barred from a race to which it is otherwise eligible by reason of its preference due to the fact that it has been drawn as an also eligible. A horse put into the race from the also eligible list cannot be drawn except by permission of the stewards, but the owner or trainer of the horse shall be notified that the horse is to race and the notification shall be posted at the racing secretary's office. All horses on the also eligible list and not moved into the race by scratch time for the race shall be released.

e. Preference.

(1) Preference shall be given in all overnight events according to a horse's last purse race during the current year. The preference date on a horse that has drawn to race and been scratched is the date of the race from which it was scratched.

(2) When a horse is racing for the first time in the current year, the date of the first successful qualifying race shall be considered its last race date and preference shall be applied accordingly.

(3) If an error has been made in determining or posting a preference date and the error deprives an eligible horse of an opportunity to race, the trainer involved shall report the error to the racing secretary within one hour of the announcement of the draw. If in fact a preference date error has occurred, the race will be redrawn.

(4) Exclusion of single interest. Horses having the same owner, lessee, or trainer shall not be permitted to enter or start if the effect would deprive a single interest from starting in overnight races.

(5) Whenever horses have equal preference in a race, the actual preference of said horses in relation to one another shall be determined from the most recent previous starts which do not result in equal preference.

(6) When an overnight race has been reopened because it did not fill, all eligible horses declared into the race prior to the reopening shall receive preference over other horses subsequently declared, irrespective of the actual preference dates.

f. Stewards' list.

(1) A horse that is unfit to race because it is dangerous, unmanageable, sick, lame, unable to show a performance to qualify for races at the meeting, or is otherwise unfit to race at the meeting, may be placed on a stewards' list by the stewards, and declarations of the horse shall be refused. The owner or trainer shall be notified in writing of such action and the reason as set forth above shall be clearly stated on the notice. When any horse is placed on the stewards' list, the clerk of the course shall make a note on the certificate or electronic eligibility certificate of such horse showing the date the horse was put on the stewards' list, the reason, and the date of removal if the horse has been removed.

(2) No steward or other official at a nonextended meeting shall have the power to remove from the stewards' list and accept as an entry any horse which has been placed on a stewards' list for the reason that it is a dangerous or unmanageable horse. Meetings may refuse declarations on any horse that has been placed on the stewards' list and has not been removed.

(3) A horse scratched from a race because of lameness or sickness may not race or enter another race for at least three days from the date scheduled to race.

g. Driver. Declarations shall state who shall drive the horse and give the driver's colors. Drivers shall be named at the time of the draw after which no driver may be changed without good cause and permission of the steward(s). All drivers must be changed by scratch time. When a nominator starts two or more horses, the stewards shall approve or disapprove the second and third drivers.

9.6(19) *Starting.*

a. With starting gate.

(1) Starter's control. The starter shall have control of the horses from the formation of the parade until giving the word "go."

(2) Scoring. After one or two preliminary warming up scores, the starter shall notify the drivers to fasten their helmets and come to the starting gate. During or before the parade, the drivers must be informed as to the number of scores permitted.

(3) Starting gate. The horses shall be brought to the starting gate as near to one-quarter of a mile before the start as the facility will permit.

(4) Speed of gate. Allowing sufficient time so that the speed of the gate can be increased gradually, the following minimum speeds will be maintained.

1. For the first one-eighth mile, not less than 11 miles per hour.
2. For the next one-sixteenth of a mile, not less than 18 miles per hour.
3. From the above point to the starting point, the speed will be increased gradually to maximum speed.

(5) On mile tracks, horses will be brought to the starting gate at the head of the stretch, and the relative speeds stated in subparagraph (4) of this subrule will be maintained.

(6) The starting point will be a point on the inside rail a distance of not less than 200 feet from the first turn. The starter shall give the word "go" at the starting point.

(7) When a speed has been reached in the course of a start, there shall be no decrease except in the case of a recall.

(8) Recall notice. In case of a recall, a light plainly visible to the drivers shall be flashed and a recall sounded, and whenever possible the starter shall leave the wings of the gate extended and gradually slow the speed of the gate to assist in stopping the field of horses. In an emergency, the starter shall use discretion to close the wings of the gate.

(9) There shall be no recall after the word "go" has been given and any horse, regardless of position or an accident, shall be deemed a starter from the time entered into the starter's control unless dismissed by the starter.

(10) Breaking horse. The starter shall endeavor to get all horses away in position and on gait but there shall be no recall for a breaking horse.

(11) Reason for recall. The starter may sound a recall only for the following reasons:

1. A horse scores ahead of the gate.
2. There is interference.
3. A horse has broken equipment.
4. A horse falls before the word "go" is given.
5. A starting gate malfunctions.
6. A horse comes to the starting gate out of position.

(12) Riding in gate. No person(s) shall be allowed to ride in the starting gate except the starter, driver or operator, and a patrol judge unless permission has been granted by the stewards.

(13) Loudspeaker. Use of a mechanical loudspeaker for any purpose other than to give instructions to drivers is prohibited. The volume shall be no higher than necessary to carry the voice of the starter to the drivers.

b. Holding horses before start. Horses may be held on the backstretch not to exceed two minutes awaiting post time, except when delayed by an emergency.

c. Two tiers. In the event there are two tiers of horses, the withdrawing of a horse that has drawn or earned a position in the front tier shall not affect the position of the horses that have drawn or earned positions in the second tier. Whenever a horse is withdrawn from any tier, horses on the outside shall move in to fill up the vacancy.

d. Starters. The horses shall be deemed to have started when the word "go" is given by the starter and all the horses must go the course except in case of an accident, broken equipment, or any other reason in which the stewards determine that it is impossible to go the course.

e. Unmanageable horse.

(1) If, in the opinion of the stewards or the starter, a horse is unmanageable or liable to cause accidents or injury to any other horse or to any driver, it may be sent to the barn. When this action is taken, the stewards will notify the public.

(2) A horse shall be considered unmanageable if it causes more than one recall in the same dash or heat and the horse shall be excused by the starter.

f. Post positions; heat racing. The horse winning the first heat shall take the pole (or inside position) in the succeeding heat, unless otherwise specified in the published conditions, and all others shall take their positions in the order they were placed in the last heat. When two or more horses have made a dead heat, their positions shall be settled by lot.

9.6(20) *Racing and track.*

a. Although a leading horse is entitled to any part of the track, except after selecting its position in the home stretch, neither the driver of the first horse nor any other driver in the race shall do any of the following:

(1) Change either to the right or left during any part of the race when another horse is so near that altering its position compels the horse behind to shorten its stride or causes the driver of the other horse to pull out of its stride.

(2) Jostle, strike, hook wheels, or interfere with another horse or driver.

(3) Cross sharply in front of a horse or cross over in front of a field of horses in a reckless manner, endangering other drivers.

(4) Swerve in and out or pull up quickly.

(5) Crowd a horse or driver by "putting a wheel under them."

(6) "Carry a horse out" or "sit down in front" of a horse or take up abruptly in front of other horses so as to cause confusion or interference among the trailing horses.

(7) Let a horse pass inside needlessly or otherwise help another horse to improve its position in the race.

(8) Lay off a normal pace and leave a hole when it is well within the horse's capacity to keep the hole closed.

(9) Commit any act which shall impede the progress of another horse or cause it to "break."

(10) Change course after selecting a position in the home stretch, swerve in or out, or bear in or out to interfere with another horse or cause it to change course or take back.

(11) Drive in a careless or reckless manner.

(12) Whip under the arch of the sulky.

(13) Kick the horse.

(14) Fail to set or maintain a pace comparable to the class in which the driver is racing by going an excessively slow quarter or any other distance that changes the normal pattern, overall timing, or general outcome of the race.

(15) Cross the inside limits of the course.

b. Complaints—reports of interference.

(1) Complaints. All complaints by drivers of any foul driving or other misconduct during the heat must be made to the starter at the termination of the heat, unless the driver is prevented from doing so by an accident or injury. Any driver desiring to enter a claim of foul or other complaint of violation of the rules must, before dismounting, indicate to the starter the desire to enter the claim or complaint and, upon dismounting, shall proceed to the telephone or stewards' stand where the claim, objection, or complaint shall be immediately entered. The stewards shall not cause the official sign to be displayed until the claim, objection, or complaint has been entered and considered.

(2) Report of interference. It is the duty of every driver to report to the official designated for that purpose, as promptly as possible after the conclusion of a race in which the driver has participated, any material interference to the driver or the horse by another horse or driver during a race.

c. If any of the above violations are committed by a person driving a horse coupled as an entry in the betting, the stewards shall set the offending horse back. The horse coupled in the entry with the offending horse shall also be set back if the stewards find that it improved its finishing position as a direct result of the offense committed by the offending horse.

d. In the case of interference, collision, or violation of any of the above restrictions, whether occurring before or after the start, the offending horse may be placed back one or more positions in that heat or dash and, in the event the collision or interference prevents any horse from finishing the heat or dash, the offending horse may be disqualified from receiving any winnings; and the driver may be subject to discipline. In the event a horse is set back, it must be placed behind the horse with whom it interfered.

e. Unsatisfactory drive—fraud. Every heat in a race must be contested by every horse in the race and every horse must be driven to the finish. If the stewards believe that a horse is being driven or has been driven to prevent winning a heat or dash which it was evidently able to win, in an inconsistent manner, or to perpetrate or to aid a fraud, they shall consider it a violation and the driver and anyone in concert with the driver to so affect the outcome of the race(s) may be subject to disciplinary action. The stewards may substitute a competent and reliable driver at any time. The substitute driver shall be paid at the discretion of the stewards and the fee shall be retained from the purse money due the horse, if any.

In the event a drive is unsatisfactory due to lack of effort or carelessness, and the stewards believe that there is no fraud, gross carelessness, or a deliberate inconsistent drive, they shall impose a penalty.

f. If, in the opinion of the stewards, a driver is for any reason unfit or incompetent to drive, refuses to comply with the directions of the stewards, or is reckless in conduct and endangers the safety of horses or other drivers in the race, the driver may be removed and another driver substituted at any time after the positions have been assigned in a race, and the offending driver shall be subject to discipline. The substitute driver shall be properly compensated.

g. If, for any cause other than being interfered with or broken equipment, a horse fails to finish after starting in a heat, that horse shall be ruled out.

h. Loud shouting or other improper conduct is forbidden in a race. After the starting gate is in motion, both feet must be kept in the stirrups until after the finish of the race, except that a driver shall be allowed to remove a foot from the stirrups temporarily for the purpose of pulling earplugs.

i. Drivers will be allowed whips not to exceed three feet nine inches, plus a snapper not longer than six inches. Provided further that the following actions may be considered as excessive or indiscriminate use of the whip:

(1) Causing visible injury to a horse.

(2) Whipping a horse after a race.

j. A driver using any goading device, chain, or mechanical devices or appliances, other than the ordinary whip or crop, upon any horse in any race shall be subject to discipline.

k. The brutal, excessive, or indiscriminate use of the whip or crop shall be considered a violation. A driver may use a whip only in the conventional manner. Welts, cuts, or whip marks on a horse resulting from whipping shall constitute a violation of this subrule. Drivers are prohibited from punching or jabbing a horse, or using the whip so as to interfere with or cause disturbance to any other horse or driver in a race.

l. No horse shall wear hopples in a race unless it starts with the hopples in the first heat and, having so started, it shall continue to wear them to the finish of the race. Any person found guilty of removing or altering a horse's hopples during a race, or between races, for the purpose of fraud, shall be suspended or expelled. Any horse habitually wearing hopples shall not be permitted to start in a race without them except by permission of the stewards. Any horse habitually racing free-legged shall not be permitted to wear hopples in a race except with the permission of the stewards. No horse shall be permitted to wear a head pole protruding beyond its nose.

m. Breaking.

(1) When any horse breaks from its gait in trotting or pacing, its driver shall at once, where clearance exists, take such horse to the outside and pull it to its gait.

(2) The following shall be considered violations of subparagraph 9.6(20)*"m"*(1):

1. Failure to properly attempt to pull the horse to its gait.
2. Failure to take to the outside where clearance exists.
3. Failure to lose ground by the break.

(3) Any breaking horse shall be set back when a contending horse on its gait is lapped on the hind quarter of the breaking horse at the finish.

(4) Any horse making a break which causes interference to other contending horses may be placed behind all offended horses; if there has been no failure on the part of the driver of the breaking horse in complying with subparagraph 9.6(20)*"m"*(2) above, no fine or suspension shall be imposed on the driver as a consequence of the interference.

(5) The stewards may set any horse back one or more places if, in their judgment, any of the above violations have been committed.

If, in the opinion of the stewards, a driver allows the horse to break for the purpose of fraudulently losing a heat, then the driver shall be subject to the penalties elsewhere provided for fraud and fouls.

To assist in determining the matters contained in paragraphs 9.6(20)*"m"* and 9.6(20)*"n,"* it shall be the duty of one of the stewards to call out every break made, and the clerk shall at once note the break and character of it in writing.

n. The time between separate heats of a single race shall be no less than 40 minutes. The time between the heats shall not exceed one hour and 30 minutes. No heat shall be called after sunset when the track is not lighted for night racing.

o. Horses called for a race shall have the exclusive right of the course, and all other horses shall vacate the track at once, unless permitted to remain by the stewards.

p. In the case of accidents, only so much time shall be allowed as the stewards may deem necessary and proper.

q. A driver must be mounted in the sulky at the finish of the race or the horse must be placed as not finishing.

r. It shall be the responsibility of the owner and trainer to provide every sulky used in a race with unicolored or colorless wheel discs on the inside and outside of the wheel of a type approved by the commission. In their discretion, the stewards may order the use of mudguards at pari-mutuel tracks.

s. Sulky. Only sulkies of the conventional dual-shaft and dual-hitch type shall be permitted to be used in any races. A conventional-type sulky is one having two shafts that must be parallel to and securely hitched on each side of the horse. No point of hitch or any part of a shaft shall be above a horizontal level equal to the lowest point of the horse's back.

t. Excessive or unnecessary conversation between and among drivers while on the racetrack during the time when colors are required is prohibited.

u. If, at any racetrack which does not have a continuous solid inside hub rail, a horse or part of the horse sulky leaves the course by going inside the hub rail or other demarcation which constitutes the inside limits of the course, the offending horse shall be placed back one or more positions where, in the opinion of the stewards, the action gave the horse an unfair advantage over other horses in the race, or the action helped the horse improve its position in the race. In addition, when an act of interference causes a horse or part of the horse's sulky to cross the inside limits of the course, and the horse is placed by the judges, the offending horse shall be placed behind the horse with which it interfered.

9.6(21) *Protests.*

a. Protests may be made only by an owner, manager, trainer, or driver of one of the contending horses at any time before the winnings are paid over and shall be in writing, sworn to, and contain at least one specific charge, which, if true, would prevent the horse from winning or competing in the race.

b. The stewards shall in every case of protest demand that the driver, and the owner or owners if present, immediately testify under oath and, in case of their refusal to do so, the horse shall not be allowed to start or continue in the race, but shall be ruled out, with a forfeit of entrance money.

c. Unless the stewards find satisfactory evidence to warrant excluding the horse, they shall allow the horse to start or continue in the race under protest, and the premium, if any, won by that horse shall be forthwith transmitted to the commission to allow the parties interested an opportunity to sustain the allegation of the protest or furnish information which will warrant an investigation of the matter. When no action is taken to sustain the protest within 30 days, payment may be made as if such protest had not been filed.

d. Any person found guilty of protesting a horse falsely and without cause, or merely with intent to embarrass a race, shall be subject to discipline.

e. Nothing here contained shall affect the distribution of pari-mutuel pools when the distribution is made upon the official placing at the conclusion of the heat or dash.

f. In case of an appeal or protest, the purse money affected will be deposited with the commission in trust funds pending the decision of the appeal.

9.6(22) *Timing and records.*

a. Timing races. In every race, the time of each heat shall be accurately taken by three timers or an approved electric timing device, in which case there shall be one timer; placed in the record in minutes, seconds, and fifths of seconds; and, upon the decision of each heat, the time shall be publicly announced or posted. No unofficial timing shall be announced or admitted to the record and, when the timers fail to act, no time shall be announced or recorded for that heat.

b. Error in reported time. In any case of alleged error in the record, announcement, or publication of the time made by a horse, the time so questioned shall not be changed to favor the horse or owner, except upon the sworn statement of the stewards and timers who officiated in the race.

c. Time, where lapped on. The leading horse shall be timed and that time only shall be announced. No horse shall obtain a win race record by reason of the disqualification of another horse unless the horse's actual race time can be determined by photo finish or electronic timing.

d. Time for dead heat. In case of a dead heat, the time shall constitute a record for the horses making a dead heat and both shall be considered winners.

e. Timing procedure. The time shall be recorded from the instant that the first horse leaves the point from which the distance is measured until the first horse reaches the finish line. The time of the leading horse at the quarter, half, three-quarters and the finish shall be taken.

f. Fraudulent misrepresentation. Any person guilty of fraudulent misrepresentation of time or the alteration of the record in any public race shall be fined, suspended, or expelled, and the time declared not a record.

9.6(23) *Heat number and saddle pads; entry number.* Each competing horse shall be equipped with numbers of style, type, and design approved by the commission or its representatives. Numbers shall be so arranged that coupled entries may be distinguished.

9.6(24) *Paddock.* The paddock or receiving barn must be completely enclosed with a secure fence and each opening through the fence shall be policed by a person or persons licensed by this commission so as to exclude unauthorized personnel. A daily record of all persons entering or leaving the paddock from one hour prior to post time until all races of that program have been completed shall be maintained on forms approved by the commission.

9.6(25) *Other facility conditions.*

a. Default in payment of purses. Any facility that defaults in the payment of a premium that has been raced for shall stand suspended, together with its officers.

b. If, at a meeting of a facility, a race is contested which has been promoted by another party or parties, and the promoters default in the payment of the amount raced for, the same liability shall attach to the facility as if the race had been offered by it.

c. Removal of horses from facility premises. No horse shall be ordered off the premises without at least 72 hours' notice (excluding Sunday) to the person in charge of the horse.

[**ARC 9987B**, IAB 2/8/12, effective 3/14/12]

491—9.7(99D) Medication and administration, sample collection, chemists, and practicing veterinarian.

9.7(1) *Medication and administration.*

a. No horse, while participating in a race, shall carry in its body any medication, drug, foreign substance, or metabolic derivative thereof, which is a narcotic or which could serve as a local anesthetic or tranquilizer or which could stimulate or depress the circulatory, respiratory, or central nervous system of a horse, thereby affecting its speed.

b. Also prohibited are any drugs or foreign substances that might mask or screen the presence of the prohibited drugs, or prevent or delay testing procedures.

c. Proof of detection by the commission chemist of the presence of a medication, drug, foreign substance, or metabolic derivative thereof, prohibited by paragraph 9.7(1)*"a"* or *"b"* in a saliva, urine, or blood sample duly taken under the supervision of the commission veterinarian from a horse immediately prior to or promptly after running in a race shall be prima facie evidence that the horse was administered, with the intent that it would carry or that it did carry in its body while running in a race, prohibited medication, drug, or foreign substance in violation of this rule.

d. Administration or possession of drugs.

(1) No person shall administer, cause to be administered, participate or attempt to participate in any way in the administration of any medication, drug, foreign substance, or treatment by any route to a horse registered for racing on the day of the race for which the horse is entered prior to the race.

(2) No person except a veterinarian shall have in the person's possession any prescription drug. However, a person may possess a noninjectable prescription drug for animal use if:

1. The person actually possesses, within the racetrack enclosure, documentary evidence that a prescription has been issued to said person for such a prescription drug.

2. The prescription contains a specific dosage for the particular horse or horses to be treated by the prescription drug.

3. The horse or horses named in the prescription are in said person's care within the racetrack enclosure.

(3) No veterinarian or any other person shall have in their possession or administer to any horse within any racetrack enclosure any chemical or biological substance which:

1. Has not been approved for use on equines by the Food and Drug Administration pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. Section 301 et seq., and implementing regulations, without the prior written approval from a commission veterinarian, after consulting with the stewards.

2. Is on any of the schedules of controlled substances as prepared by the Attorney General of the United States pursuant to 21 U.S.C. Sections 811 and 812, without the prior written approval from a commission veterinarian after consultation with the stewards. The commission veterinarian shall not give such approval unless the person seeking the approval can produce evidence in recognized veterinary journals or by recognized equine experts that such chemical substance has a beneficial therapeutic use in horses.

(4) No veterinarian or any other person shall dispense, sell, or furnish to any person any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route within the premises of the facility unless there is a label specifying the name of the substance dispensed, the name of the dispensing person, the name of the horse or horses for which the substance is dispensed, the purpose for which said substance is dispensed, the dispensing veterinarian's recommendations for withdrawal before racing (if applicable), and the name of the person to which dispensed, or is otherwise labeled as required by law.

(5) No person shall have in the person's possession or in areas under said person's responsibility on facility premises any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route unless it complies with the labeling requirements in 9.7(1)*"d"*(4).

e. Any person found to have administered or caused, participated in, or attempted to participate in any way in the administration of a medication, drug, or foreign substance that caused or could have caused a violation of this rule, shall be subject to disciplinary action.

f. The owner, trainer, groom, or any other person having charge, custody, or care of the horse is obligated to protect the horse properly and guard it against the administration or attempted administration of a substance in violation of this rule. If the stewards find that any person has failed to show proper protection and guarding of the horse, or if the stewards find that any owner, lessee, or trainer is guilty of negligence, they shall impose discipline and take other action they deem proper under any of the rules including referral to the commission.

g. In order for a horse to be placed on the bleeder list in Iowa through reciprocity, that horse must be certified as a bleeder in another state or jurisdiction. A certified bleeder is a horse that has raced with furosemide in another state or jurisdiction in compliance with the laws governing furosemide in that state or jurisdiction.

h. The possession or use of blood doping agents, including but not limited to those listed below, on the premises of a facility under the jurisdiction of the commission is forbidden:

(1) Erythropoietin;

(2) Darbepoetin;

(3) Oxyglobin®; and

(4) Hemopure®.

i. The use of extracorporeal shock wave therapy or radial pulse wave therapy machines shall not be permitted unless the following conditions are met:

(1) Any treated horse shall not be permitted to race for a minimum of ten days following treatment;

(2) The use of extracorporeal shock wave therapy or radial pulse wave therapy machines shall be limited to veterinarians licensed to practice by the commission;

(3) Any extracorporeal shock wave therapy or radial pulse wave therapy machines on the association grounds must be registered with and approved by the commission or its designee before use;

(4) All extracorporeal shock wave therapy or radial pulse wave therapy treatments must be reported to the official veterinarian on the prescribed form not later than the time prescribed by the official veterinarian.

j. The use of a nasogastric tube (a tube longer than six inches) for the administration of any substance within 24 hours prior to the post time of the race in which the horse is entered is prohibited without the prior permission of the official veterinarian or designee.

k. Non-steroidal anti-inflammatory drugs (NSAIDs).

(1) The use of one of three approved NSAIDs shall be permitted under the following conditions:

1. Not to exceed the following permitted serum or plasma threshold concentrations which are consistent with administration by a single intravenous injection at least 24 hours before the post time for the race in which the horse is entered:

- Phenylbutazone (or its metabolite oxyphenylbutazone) – 5 micrograms per milliliter;
- Flunixin – 20 nanograms per milliliter;
- Ketoprofen – 10 nanograms per milliliter.

2. The NSAIDs listed in numbered paragraph "1" or any other NSAIDs are prohibited from being administered within the 24 hours before post time for the race in which the horse is entered.

3. The presence of more than one of the three approved NSAIDs, with the exception of phenylbutazone in a concentration below 1 microgram per milliliter of serum or plasma, or the presence of any unapproved NSAID in the post race serum or plasma sample is not permitted. The use of all but one of the approved NSAIDs shall be discontinued at least 48 hours before the post time for the race in which the horse is entered.

(2) Any horse to which an NSAID has been administered shall be subject to having a blood sample(s), urine sample(s) or both taken at the direction of the official veterinarian to determine the quantitative NSAID level(s) or the presence of other drugs which may be present in the blood or urine sample(s).

9.7(2) *Sample collection.*

a. Urine, blood, and other specimens shall be taken and tested from any horse that the stewards, commission veterinarian, or the commission's representatives may designate. The samples shall be collected by the commission veterinarian or other person or persons the commission may designate. Each sample shall be marked or numbered and bear information essential to its proper analysis; but the identity of the horse from which the sample was taken or the identity of its owners or trainer shall not be revealed to the official chemist or the staff of the chemist. The container of each sample shall be sealed as soon as the sample is placed therein.

b. A facility shall have a detention barn under the supervision of the commission veterinarian for the purpose of collecting body fluid samples for any tests required by the commission. The building,

location, arrangement, furnishings, and facilities including refrigeration and hot and cold running water must be approved by the commission. A security guard, approved by the commission, must be in attendance at each access to the detention barn during the hours designated by the commission.

c. No unauthorized person shall be admitted at any time to the building or the area utilized for the purpose of collecting the required body fluid samples or the area designated for the retention of horses pending the obtaining of body fluid samples.

d. During the taking of samples from a horse, the owner, responsible trainer, or a representative designated by the owner or trainer may be present and witness the taking of the sample and so signify in writing. Failure to be present and witness the collection of the samples constitutes a waiver by the owner, trainer, or representative of any objections to the source and documentation of the sample.

e. The commission veterinarian, the stewards, agents of the division of criminal investigation, or commission representative may take samples of any medicine or other materials suspected of containing improper medication, drugs, or other substance which could affect the racing condition of a horse in a race, which may be found in barns or elsewhere on facility premises or in the possession of any person connected with racing, and the same shall be delivered to the official chemist for analysis.

f. Nothing in these rules shall be construed to prevent:

(1) Any horse in any race from being subjected by the order of a steward or the commission veterinarian to tests of body fluid samples for the purpose of determining the presence of any foreign substance.

(2) The state steward or the commission veterinarian from authorizing the splitting of any sample.

(3) The commission or commission veterinarian from requiring body fluid samples to be stored in a frozen state for future analysis.

g. Before leaving the racing surface, the trainer shall ascertain the testing status of the horse under the trainer's care from the commission veterinarian or designated detention barn representative.

9.7(3) *Chemists.*

a. Tests are to be under the supervision of the commission which shall employ one or more chemists or contract with one or more qualified chemical laboratories to determine by chemical testing and analysis of body fluid samples whether a foreign substance, medication, drug, or metabolic derivative thereof is present.

b. All body fluid samples taken by or under direction of the commission veterinarian or commission representative shall be delivered to the laboratory of the official chemist for analysis.

c. The commission chemist shall be responsible for safeguarding and testing each sample delivered to the laboratory by the commission veterinarian.

d. The commission chemist shall conduct individual tests on each sample, screening the samples for prohibited substances, and conducting other tests to detect and identify any suspected prohibited substance or metabolic derivative thereof with specificity. Pooling of samples shall be permitted only with the knowledge and approval of the commission.

e. Upon the finding of a test negative for prohibited substances, the remaining portions of the sample may be discarded. Upon the finding of tests suspicious or positive for prohibited substances, the tests shall be reconfirmed, and the remaining portion, if available, of the sample preserved and protected for two years following close of the meet.

f. The commission chemist shall submit to the commission a written report as to each sample tested, indicating by sample tag identification number, whether the sample tested negative or positive for prohibited substances. The commission chemist shall report test findings to no person other than the administrator or commission representative, with the exception of notifying the state stewards of all positive tests.

g. In the event the commission chemist should find a sample suspicious for a prohibited medication, additional time for test analysis and confirmation may be requested.

h. In reporting to the state steward a finding of a test positive for a prohibited substance, the commission chemist shall present documentary or demonstrative evidence acceptable in the scientific community and admissible in court in support of the professional opinion as to the positive finding.

i. No action shall be taken by the state steward until an official report signed by the chemist properly identifying the medication, drug, or other substance as well as the horse from which the sample was taken has been received.

j. The cost of the testing and analysis shall be paid by the commission to the official chemist. The commission shall then be reimbursed by each facility on a per-sample basis so that each facility shall bear only its proportion of the total cost of testing and analysis. The commission may first receive payment from funds provided in Iowa Code chapter 99D, if available.

9.7(4) *Practicing veterinarian.*

a. Prohibited acts.

(1) Ownership. A licensed veterinarian practicing at any meeting is prohibited from possessing any ownership, directly or indirectly, in any racing animal racing during the meeting.

(2) Wagering. Veterinarians licensed by the commission as veterinarians are prohibited from placing any wager of money or other thing of value directly or indirectly on the outcome of any race conducted at the meeting at which the veterinarian is furnishing professional service.

(3) Prohibition of furnishing injectable materials. No veterinarian shall within the facility premises furnish, sell, or loan any hypodermic syringe, needle, or other injection device, or any drug, narcotic, or prohibited substance to any other person unless with written permission of the stewards.

b. The use of other than single-use disposable syringes and infusion tubes on facility premises is prohibited. Whenever a veterinarian has used a hypodermic needle or syringe the veterinarian shall destroy the needle and syringe and remove the needle and syringe from the facility premises.

c. Veterinarians must submit daily to the commission veterinarian on a prescribed form a report of all procedures, medications and other substances which the veterinarian prescribed, administered, or dispensed for racing animals registered at the current race meeting as provided in Iowa Code section 99D.25(10). Reports shall be submitted in a manner and at a time determined by the commission veterinarian not later than noon the day following the treatments' being reported. Reports shall include the racing animal, trainer, procedure, medication or other substance, dosage or quantity, route of administration, date and time administered, dispensed, or prescribed. Reports shall be signed by the practicing veterinarian.

d. Within 20 minutes following the administration of furosemide, the veterinarian must deliver to the commission veterinarian or commission representative a signed affidavit certifying information regarding the treatment of the horse. The statement must include, at a minimum, the name of the practicing veterinarian, the tattoo number or freeze brand number of the horse, the location of the barn and stall where the treatment occurred, the race number of the horse, the name of the trainer, and the time that the furosemide was administered. This affidavit must be signed by the trainer or trainer's designee who witnessed the administration of furosemide. The veterinarian shall not administer the furosemide if a witness is not present. Furosemide shall only be administered (by a single intravenous injection) in a dose level allowed by Iowa Code section 99D.25A, subsection 7.

e. Each veterinarian shall report immediately to the commission veterinarian any illness presenting unusual or unknown symptoms in a racing animal entrusted into the veterinarian's care.

f. Practicing veterinarians may have employees licensed as veterinary assistants working under their direct supervision. Activities of these employees shall not include direct treatment or diagnosis of any animal. The practicing veterinarian must be present if a veterinary assistant is to have access to injection devices or injectables. The practicing veterinarian shall assume all responsibility for a veterinary assistant.

g. Equine dentistry is considered a function of veterinary practice by the Iowa veterinary practice Act. Any dental procedures performed at the facility must be performed by a licensed veterinarian or a licensed veterinary assistant.

h. Unless approved by the commission veterinarian, veterinarians shall not have contact with an entered horse on race day except for the administration of furosemide.

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CHAPTER 10
THOROUGHBRED AND QUARTER HORSE RACING

491—10.1(99D) Terms defined. As used in the rules, unless the context otherwise requires, the following definitions apply:

"Age" means the age of a horse reckoned from the first day of January of the year of foaling.

"Allowance race" means an overnight race for which eligibility and weight to be carried are determined according to specified conditions that include age, sex, earnings, and number of wins.

"Also eligible" means:

1. A number of eligible horses, properly entered, which were not drawn for inclusion in a race but which become eligible according to preference or lot when an entry is scratched prior to the scratch time deadline; or
2. The next preferred nonqualifier for the finals or consolation from a set of elimination trials that will become eligible in the event a finalist is scratched by the stewards for a rule violation or is otherwise eligible if written race conditions permit.

"Appeal" means a request for the commission or its designee to investigate, consider, and review any decisions or rulings of stewards.

"Arrears" means all moneys owed by a licensee, including subscriptions, jockey fees, forfeitures, and any default incident to these rules.

"Authorized agent" means a person licensed by the commission and appointed by a written instrument, signed and acknowledged before a notary public by the owner on whose behalf the agent will act.

"Bleeder" means a horse that hemorrhages from within the respiratory tract during a race, within one and one-half hours postrace, during exercise or within one and one-half hours of exercise.

"Bleeder list" means a tabulation of all bleeders to be maintained by the commission.

"Chemist" means any official racing chemist designated by the commission.

"Claiming race" means a race in which any horse starting may be claimed (purchased for a designated amount) in conformance with the rules. (See also waived claiming rule in paragraph 10.6(18)*"k."*)

"Commission" means the racing and gaming commission.

"Conditions" means qualifications that determine a horse's eligibility to be entered in a race.

"Contest" means a competitive racing event on which pari-mutuel wagering is conducted.

"Coupled entry" means two or more contestants in a contest that are treated as a single betting interest for pari-mutuel wagering purposes. (See also "Entry.")

"Day" means a 24-hour period ending at midnight.

"Dead heat" means when the noses of two or more horses reach the finish line of a race at the same time.

"Declaration" means the act of withdrawing an entered horse from a race prior to the closing of entries.

"Detention barn" means the barn designated for the collection from horses of test samples under the supervision of the commission veterinarian; also the barn assigned by the commission to a horse on the bleeder list, for occupancy as a prerequisite for receiving bleeder medication.

"Entry" means a horse made eligible to run in a race; or two or more horses, entered in the same race, which have common ties of ownership, lease, or training. (See also "Coupled entry.")

"Facility" means an entity licensed by the commission to conduct pari-mutuel wagering or gaming operations in Iowa.

"Facility premises" means all real property utilized by the facility in the conduct of its race meeting, including the racetrack, grandstand, concession stands, offices, barns, stable area, employee housing facilities, parking lots, and any other areas under the jurisdiction of the commission.

"Field or mutuel field" means a group of two or more horses upon which a single bet may be placed. A mutuel field is required when the number of horses starting in a race exceeds the capacity of the track

totalizator. The highest numbered horse within the totalizator capacity and all the higher-numbered horses following are then grouped together in the mutuel field.

"Foreign substances" means all substances except those that exist naturally in the untreated horse at normal physiological concentration.

"Forfeit" means money due from a licensee because of an error, fault, neglect of duty, breach of contract, or penalty imposed by the stewards or the commission.

"Handicap" means a race in which the weights to be carried by the horses are assigned by the racing secretary or handicapper for the purpose of equalizing the chances of winning for all horses entered.

"Horse" means any equine (including equine designated as a mare, filly, stallion, colt, ridgeling, or gelding) registered for racing; specifically, an entire male 5 years of age and older.

"Hypodermic injection" means any injection into or under the skin or mucosa, including intradermal injection, subcutaneous injection, submucosal injection, intramuscular injection, intravenous injection, intra-arterial injection, intra-articular injection, intrabursal injection, and intraocular (intraconjunctival) injection.

"Inquiry" means an investigation by the stewards of potential interference in a contest prior to declaring the result of said contest official.

"Jockey" means a professional rider licensed to ride in races.

"Licensee" means any person or entity licensed by the commission to engage in racing or related regulated activity.

"Maiden race" means a contest restricted to nonwinners.

"Meet/meeting" means the specified period and dates each year during which a facility is authorized by the commission to conduct pari-mutuel wagering on horse racing.

"Month" means a calendar month.

"Nomination" means the naming of a horse to a certain race or series of races generally accompanied by payment of a prescribed fee.

"Nominator" means the person or entity in whose name a horse is nominated for a race or series of races.

"Objection" means:

1. A written complaint made to the stewards concerning a horse entered in a race and filed not later than one hour prior to the scheduled post time of the first race on the day in which the questioned horse is entered; or
2. A verbal claim of foul in a race lodged by the horse's jockey, trainer, owner, or the owner's authorized agent before the race is declared official.

"Official starter" means the official responsible for dispatching the horses for a race.

"Official time" means the elapsed time from the moment the first horse crosses the starting point until the first horse crosses the finish line.

"Overnight race" means a race for which entries close 96 hours, or less, before the time set for the first race of the day on which the race is to be run.

"Owner" means a person or entity that holds any title, right or interest, whole or partial, in a horse, including the lessee and lessor of a horse.

"Paddock" means an enclosure in which horses scheduled to compete in a contest are saddled prior to racing.

"Performance" means a schedule of 8 to 12 races per day unless otherwise authorized by the commission.

"Post position" means the preassigned position from which a horse will leave the starting gate.

"Post time" means the scheduled starting time for a contest.

"Prize" means the combined total of any cash, premium, trophy, and object of value awarded to the owners of horses according to order of finish in a race.

"Purse" means the total cash amount for which a race is contested.

"Purse race" means a race for money or other prize to which the owners of horses entered do not contribute money toward its purse and for which entries close less than 96 hours prior to its running.

"Race" means a running contest between horses ridden by jockeys for a purse, prize, or other reward run at a facility in the presence of the stewards of the meeting. This includes purse races, overnight races and stakes races.

"Recognized meeting" means any meeting with regularly scheduled races for horses on the flat in a jurisdiction having reciprocal relations with this state and the commission for the mutual enforcement of rulings relating to horse racing.

"Rules" means the rules promulgated by the commission to regulate the conduct of horse racing.

"Scratch" means the act of withdrawing an entered horse from a contest after the closing of entries.

"Scratch time" means the deadline set by the facility for withdrawal of entries from a scheduled performance.

"Smoke" means the procedure of reviewing entries for correctness, eligibility, weight allowances, and medications.

"Stakes race" means a contest in which nomination, entry, and starting fees contribute to the purse.

"Starter" means a horse that becomes an actual contestant in a race by virtue of the starting gate opening in front of it upon dispatch by the official starter.

"Steward" means a duly appointed racing official with powers and duties specified by rules.

"Subscription" means moneys paid for nomination, entry, eligibility, or starting of a horse in a stakes race.

"Test level" means the concentration of a foreign substance found in the test sample.

"Test sample" means any bodily substance including, but not limited to, blood or urine taken from a horse under the supervision of the commission veterinarian and as prescribed by the commission for the purpose of analysis.

"Totalizator" means the system used for recording, calculating, and disseminating information about ticket sales, wagers, odds, and payoff prices to patrons at a pari-mutuel wagering facility.

"Veterinarian" means a veterinarian holding a current unrestricted license issued by the state of Iowa veterinary regulatory authority and licensed by the commission.

"Winner" means the horse whose nose reaches the finish line first or is placed first through disqualification by the stewards.

"Year" means a calendar year.

[**ARC 9987B**, IAB 2/8/12, effective 3/14/12]

491—10.2(99D) Facilities' responsibilities.

10.2(1) *Stalls.* The facility shall ensure that racing animals are stabled in individual box stalls; that the stables and immediate surrounding area are maintained in approved sanitary condition at all times; that satisfactory drainage is provided; and that manure and other refuse are kept in separate boxes or containers at locations distant from living quarters and promptly and properly removed.

10.2(2) *Paddocks and equipment.* The facility shall ensure that paddocks, starting gates, and other equipment subject to contact by different animals are kept in a clean condition and free of dangerous surfaces.

10.2(3) *Receiving barn and stalls.* Each facility shall provide a conveniently located receiving barn or stalls for the use of horses arriving during the meeting. The barn shall have adequate stable room and facilities, hot and cold water, and stall bedding. The facility shall employ attendants to operate and maintain the receiving barn or stalls in a clean and healthy condition.

10.2(4) *Fire protection.* The facility shall develop and implement a program for fire prevention on facility premises in accordance with applicable state fire codes. The facility shall instruct employees working on facility premises in procedures for fire prevention and evacuation. The facility shall, in accordance with state fire codes, prohibit the following:

a. Smoking in horse stalls, feed and tack rooms, and in the alleyways.

b. Sleeping in feed rooms or stalls.

c. Open fires and oil- or gasoline-burning lanterns or lamps in the stable area.

d. Leaving any electrical appliance unattended or in unsafe proximity to walls, beds, or furnishings.

e. Keeping flammable materials, including cleaning fluids or solvents, in the stable area.

f. Locking a stall which is occupied by a horse.

The facility shall post a notice in the stable area which lists the prohibitions outlined in 10.2(4)*"a"* to *"f"* above.

10.2(5) *Starting gate.*

a. During racing hours a facility shall provide at least two operable padded starting gates that have been approved by the commission.

b. During designated training hours a facility shall make at least one starting gate and qualified starting gate employee available for schooling.

c. If a race is started at a place other than in a chute, the facility shall provide and maintain in good operating condition backup equipment for moving the starting gate. The backup equipment must be immediately available to replace the primary moving equipment in the event of failure.

10.2(6) *Distance markers.*

a. A facility shall provide and maintain starting point markers and distance poles in a size and position that can be clearly seen from the steward's stand.

b. The starting point markers and distance poles must be marked as follows:

1/4 poles	red and white horizontal stripes
1/8 poles	green and white horizontal stripes
1/16 poles	black and white horizontal stripes
220 yards	green and white
250 yards	blue
300 yards	yellow
330 yards	black and white
350 yards	red
400 yards	black
440 yards	red and white
550 yards	black and white horizontal stripes
660 yards	green and white horizontal stripes
770 yards	black and white horizontal stripes
870 yards	blue and white horizontal stripes

10.2(7) *Detention enclosure.* Each facility shall maintain a detention enclosure for use by the commission for securing samples of urine, saliva, blood, or other bodily substances or tissues for chemical analysis from horses who have run in a race. The enclosure shall include a wash rack, commission veterinarian office, a walking ring, at least four stalls, workroom for the sample collectors with hot and cold running water, and glass observation windows for viewing of the horses from the office and workroom. An owner, trainer, or designated representative licensed by the commission shall be with a horse in the detention barn at all times.

10.2(8) *Ambulance.* A facility shall maintain, on the premises during every day that its track is open for racing or exercising, an ambulance for humans and an ambulance for horses, equipped according to prevailing standards and staffed by medical doctors, paramedics, or other personnel trained to operate them. When an ambulance is used for transfer of a horse or patient to medical facilities, a replacement ambulance must be furnished by the facility to comply with this rule.

10.2(9) *Helmets and vests.* A facility shall not allow any person on horseback on facility grounds unless that person is wearing a protective helmet and safety vest of a type approved by the commission.

10.2(10) *Racetrack.*

a. The surface of a racetrack, including cushion, subsurface, and base, must be designed, constructed, and maintained to provide for the safety of the jockeys and racing animals.

b. Distances to be run shall be measured from the starting line at a distance three feet out from the inside rail.

c. A facility shall provide an adequate drainage system for the racetrack.

d. A facility shall provide adequate equipment and personnel to maintain the track surface in a safe training and racing condition. The facility shall provide backup equipment for maintaining the track surface. A facility that conducts races on a turf track shall:

(1) Maintain an adequate stockpile of growing medium; and

(2) Provide a system capable of adequately watering the entire turf course evenly.

e. Rails.

(1) Racetracks, including turf tracks, shall have inside and outside rails, including gap rails, designed, constructed, and maintained to provide for the safety of jockeys and horses. The design and construction of rails must be approved by the commission prior to the first race meeting at the track.

(2) The top of the rail must be at least 38 inches but not more than 44 inches above the top of the cushion. The inside rail shall have no less than a 24-inch overhang with a continuous smooth cover.

(3) All rails must be constructed of materials designed to withstand the impact of a horse running at a gallop.

10.2(11) *Patrol films or video recordings.* Each facility shall provide:

a. A video recording system approved by the commission. Cameras must be located to provide clear panoramic and head-on views of each race. Separate monitors, which simultaneously display the images received from each camera and are capable of simultaneously displaying a synchronized view of the recordings of each race for review, shall be provided in the stewards' stand. The location and construction of video towers must be approved by the commission.

b. One camera, designated by the commission, to record the prerace loading of all horses into the starting gate and to continue to record until the field is dispatched by the starter.

c. One camera, designated by the commission, to record the apparent winner of each race from the finish line until the horse has returned, the jockey has dismounted, and the equipment has been removed from the horse.

d. At the discretion of the stewards, video camera operators to record the activities of any horses or persons handling horses prior to, during, or following a race.

e. That races run on an oval track be recorded by at least three video cameras. Races run on a straight course must be recorded by at least two video cameras.

f. Upon request of the commission, without cost, a copy of a video recording of a race.

g. That video recordings recorded prior to, during, and following each race be maintained by the facility for not less than six months after the end of the race meeting, or such other period as may be requested by the stewards or the commission.

h. A viewing room in which, on approval by the stewards, an owner, trainer, jockey, or other interested individual may view a video recording of a race.

i. Following any race in which there is an inquiry or objection, the video recorded replays of the incident in question which were utilized by the stewards in making their decision. The facility shall display to the public these video recorded replays on designated monitors.

10.2(12) *Communications.*

a. Each facility shall provide and maintain in good working order a communication system between:

(1) The stewards' stand;

(2) The racing office;

(3) The tote room;

(4) The jockeys' room;

(5) The paddock;

(6) The test barn;

(7) The starting gate;

(8) The weigh-in scale;

(9) The video camera locations;

(10) The clocker's stand;
(11) The racing veterinarian;
(12) The track announcer;
(13) The location of the ambulances (equine and human); and
(14) Other locations and persons designated by the commission.

b. A facility shall provide and maintain a public address system capable of clearly transmitting announcements to the patrons and to the stable area.

491—10.3(99D) Facility policies. It shall be the affirmative responsibility and continuing duty of each occupational licensee to follow and comply with the facility policies as published in literature distributed by the facility or posted in a conspicuous location.

491—10.4(99D) Racing officials.

10.4(1) *General description.* Every facility conducting a race meeting shall appoint at least the following officials:

a. One of the members of a three-member board of stewards;
b. Racing secretary;
c. Assistant racing secretary;
d. Paddock judge;
e. Horse identifier;
f. Clerk of the course;
g. Starter;
h. Clocker/timer;
i. Three placing judges;
j. Jockey room custodian;
k. Mutuel manager;
l. Clerk of scales;
m. Minimum of two outriders;
n. Horsemen's bookkeeper;
o. Any other person designated by the commission.

10.4(2) *Officials' prohibited activities.* No racing official or racing official's assistant(s) listed in 10.4(1) while serving in that capacity during any meeting may engage in any of the following:

a. Enter into a business or employment that would be a conflict of interest, interfere with, or conflict with the proper discharge of duties including a business that does business with a facility or a business issued a concession operator's license;

b. Participate in the sale, purchase, or ownership of any horse racing at the meeting;

c. Be involved in any way in the purchase or sale of any contract on any jockey racing at the meeting;

d. Sell or solicit horse insurance on any horse racing at the meeting, or any other business sales or solicitation not a part of the official's duties;

e. Wager on the outcome of any race under the jurisdiction of the commission;

f. Accept or receive money or anything of value for the official's assistance in connection with the official's duties;

g. Consume or be under the influence of alcohol or any prohibited substance while performing official duties.

10.4(3) *Single official appointment.* No official appointed to any meeting, except placing judges, may hold more than one official position listed in 10.4(1) unless, in the determination of the stewards or commission, the holding of more than one appointment would not subject the official to a conflict of interest or duties in the two appointments.

10.4(4) *Stewards.* (For practice and procedure before the stewards and the commission, see 491—Chapter 4.)

a. General authority.

(1) General. The board of stewards for each racing meet shall be responsible to the commission for the conduct of the racing meet in accordance with the laws of this state and the rules adopted by the commission. The stewards shall have authority to regulate and to resolve conflicts or disputes between all other racing officials, licensees, and those persons addressed by 491—paragraph 4.6(5)*"e,"* which are reasonably related to the conduct of a race or races and to discipline violators of these rules in accordance with the provisions of these rules.

(2) Period of authority. The stewards' authority as set forth in this subrule shall commence 30 days prior to the beginning of each racing meet and shall terminate 30 days after the end of each racing meet or with the completion of their business pertaining to the meeting.

(3) Attendance. All three stewards shall be present in the stand during the running of each race.

(4) Appointment of substitute. Should any steward be absent at race time, the state steward(s) shall appoint a deputy for the absent steward. If any deputy steward is appointed, the commission shall be notified immediately by the stewards.

(5) Initiate action. The stewards shall take notice of questionable conduct or rule violations, with or without complaint, and shall initiate investigations promptly and render a decision on every objection and every complaint made to them.

(6) General enforcement provisions. Stewards shall enforce the laws of Iowa and the rules of the commission. The laws of Iowa and the rules of racing apply equally during periods of racing. They supersede the conditions of a race and the regulations of a racing meet and, in matters pertaining to racing, the orders of the stewards supersede the orders of the officers of the facility. The decision of the stewards as to the extent of a disqualification of any horse in any race shall be final for purposes of distribution of the pari-mutuel pool.

b. Other powers and authority.

(1) The stewards shall have the power to interpret the rules and to decide all questions not specifically covered by them.

(2) All questions within their authority shall be determined by a majority of the stewards.

(3) The stewards shall have control over and access to all areas of the facility premises.

(4) The stewards shall have the authority to determine all questions arising with reference to entries and racing. Persons entering horses to run at licensed facilities agree in so doing to accept the decision of the stewards on any questions relating to a race or racing. The stewards, in their sole discretion, are authorized to determine whether two or more individuals or entities are operating as a single financial interest or as separate financial interests. In making this determination, the stewards shall consider all relevant information including, but not limited to, the following:

1. Whether the parties pay bills from and deposit receipts in the same accounts.

2. Whether the parties share resources such as employees, feed, supplies, veterinary and farrier services, exercise and pony riders, tack, and equipment.

3. Whether the parties switch horses or owner/trainer for no apparent reason, other than to avoid restrictions of being treated as a single interest.

4. Whether the parties engage in separate racing operations in other jurisdictions.

5. Whether the parties have claimed horses, or transferred claimed horses after the fact, for the other's benefit.

6. If owners, whether one owner is paying the expenses for horses not in the owner's name as owner.

7. If trainers, whether the relationship between the parties is more consistent with that of a trainer and assistant trainer.

(5) The stewards shall have the authority to discipline, for violation of the rules, any person subject to their control and, in their discretion, to impose fines or suspensions or both for infractions.

(6) The stewards shall have the authority to order the exclusion or ejection from all premises and enclosures of the facility any person who is disqualified for corrupt practices on any race course in any country.

(7) The stewards shall have the authority to call for proof that a horse is itself not disqualified in any respect, or nominated by, or, wholly or in part, the property of, a disqualified person. In default of proof being given to their satisfaction, the stewards may declare the horse disqualified.

(8) The stewards shall have the authority at any time to order an examination of any horse entered for a race or which has run in a race.

(9) In order to maintain necessary safety and health conditions and to protect the public confidence in horse racing as a sport, the stewards have the authority to authorize a person(s) on their behalf to enter into or upon the buildings, barns, motor vehicles, trailers, or other places within the premises of a facility, to examine same, and to inspect and examine the person, personal property, and effects of any person within such place, and to seize any illegal articles or any items as evidence found.

(10) The stewards shall maintain a log of all infractions of the rules and of all rulings of the stewards upon matters coming before them during the race meet.

(11) The state stewards must give prior approval for any person other than the commissioners or commission representative to be allowed in the stewards' stand.

c. Emergency authority.

(1) Substitute officials. When in an emergency, any official is unable to discharge the official's duties, the stewards may approve the appointment of a substitute and shall report it immediately to the commission.

(2) Substitute jockeys. The stewards have the authority, in an emergency, to place a substitute jockey on any horse in the event the trainer does not do so. Before using that authority, the stewards shall in good faith attempt to inform the trainer of the emergency and to afford the trainer the opportunity to appoint a substitute jockey. If the trainer cannot be contacted, or if the trainer is contacted but fails to appoint a substitute jockey and inform the stewards of the substitution by 30 minutes prior to post time, then the stewards may appoint under this rule.

(3) Substitute trainer. The stewards have the authority in an emergency to designate a substitute trainer for any horse.

(4) Excuse horse. In case of accident or injury to a horse or any other emergency deemed by the stewards before the start of any race, the stewards may excuse the horse from starting.

(5) Exercise authority. No licensee may exercise a horse on the track between races unless upon the approval of the stewards.

(6) Nonstarter. At the discretion of the stewards, any horse(s) precluded from having a fair start may be declared a nonstarter, and any wagers involving said horse(s) may be ordered refunded.

d. Investigations and decisions.

(1) Investigations. The stewards may, upon direction of the commission, conduct inquiries and shall recommend to the commission the issuance of subpoenas to compel the attendance of witnesses and the production of reports, books, papers, and documents for any inquiry. The commission stewards have the power to administer oaths and examine witnesses. The stewards shall submit a written report to the commission of every such inquiry made by them.

(2) Form reversal. The stewards shall take notice of any marked reversal of form by any horse and shall conduct an inquiry of the horse's owner, trainer, or other persons connected with the horse including any person found to have contributed to the deliberate restraint or impediment of a horse in order to cause it not to win or finish as near as possible to first.

(3) Fouls.

1. Extent of disqualification. Upon any claim of foul submitted to them, the stewards shall determine the extent of any disqualification and place any horse found to be disqualified behind others in the race with which it interfered or may place the offending horse last in the race. The stewards at their discretion may determine if there was sufficient interference or intimidation to affect the outcome of the race and take the appropriate actions thereafter.

2. Coupled entry. When a horse is disqualified under 10.4(4)*"d"*(3)"1" and that horse was a part of a coupled entry and, in the opinion of the stewards, the act which led to the disqualification served to unduly benefit the other part of the coupled entry, the stewards may disqualify the other part of the entry.

3. Jockey guilty of foul. The stewards may discipline any jockey whose horse has been disqualified as a result of a foul committed during the running of a race.

(4) Protests and complaints. The stewards shall investigate promptly and render a decision in every protest and complaint made to them. They shall keep a record of all protests and complaints and any rulings made by the stewards and shall file reports daily with the commission.

1. Involving fraud. Protests involving fraud may be made by any person at any time. The protest must be made to the stewards.

2. Not involving fraud. Protests, except those involving fraud, may be filed only by the owner of a horse, authorized agent, trainer, or the jockey of the horse in the race over which the protest is made. The protest must be made to the clerk of scales, the stewards, or a person designated by the stewards before the race is declared official. If the placement of the starting gate is in error, no protest may be made, unless entered prior to the start of the race.

3. Protest to clerk of scales. A jockey who intends to enter a protest following the running of any race, and before the race is declared official, shall notify the clerk of scales, or a person designated by the stewards, of this intention immediately upon the arrival of the jockey at the scales.

4. Prize money of protested horse. During the time of determination of a protest, any money or prize won by a horse protested or otherwise affected by the outcome of the race shall be paid to and held by the horsemen's bookkeeper until the protest is decided.

5. Protest in writing. A protest, other than one arising out of the actual running of a race, must be in writing, signed by the complainant, and filed with the stewards not later than one hour before post time of the race out of which the protest arises.

6. Frivolous protests. No person shall make a frivolous protest nor may any person withdraw a protest without the permission of the stewards.

e. Cancel wagering. The stewards have the authority to cancel wagering on an individual betting interest or on an entire race and also have the authority to cancel a pari-mutuel pool for a race or races if such action is necessary to protect the integrity of pari-mutuel wagering.

10.4(5) *Racing secretary.*

a. General authority. The racing secretary is responsible for setting the conditions for each race of the meeting, regulating the nomination of entries, determining the amounts of purses and to whom they are due, and recording of race results. The racing secretary shall permit no person other than licensed racing officials to enter the racing secretary's office or work areas until such time as all entries are closed, drawn, and smoked. Exceptions to this rule must be approved by the stewards.

b. Conditions. The racing secretary shall establish the conditions and eligibility for entering the races of the meeting and cause them to be published to owners, trainers, and the commission. Corrections to the conditions must be made before entries are taken.

c. Posting of entries. Upon the closing of entries each day, the racing secretary shall post a list of entries in a conspicuous location in the office of the racing secretary and shall furnish that list to local newspaper, radio, and television stations.

d. Stakes and entrance money records. The racing secretary shall be caretaker of the permanent records of all stakes, entrance moneys, and arrears paid or due in a race meeting and shall keep permanent records of the results of each race of the meeting.

e. Record of racing. The racing secretary shall, no later than the day following each race, attach or endorse on the registration certificate of each horse winning in any race the fact of that winning performance and the distance, date of the race, and the type or conditions of the race.

f. Daily program. The racing secretary shall publish the official daily program, ensuring the accuracy therein of the following information:

(1) The sequence of races to be run and post time for the first race;

(2) The purse, conditions and distance for each race, and current track record for such distance;

(3) The name of licensed owners of each horse, indicated as leased, if applicable, and description of racing colors to be carried;

(4) The name of the trainer and the name of the jockey named for each horse together with the weight to be carried;

(5) The post position and saddle cloth number or designation for each horse if there is a variance with the saddle cloth designation;

(6) The identification of each horse by name, color, sex, age, sire and dam; and

(7) Such other information as may be requested by the association or the commission.

g. Handicapping. The racing secretary, or a handicapper assigned by the racing secretary, shall assign the weight to be carried by each horse in a handicap when weights are not stated in the condition of the race:

(1) Scale of weights for age. The scale of weights for age hereinafter listed shall be carried when conditions of races do not otherwise specify:

Distance	Age	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	Two Years	X	X	X	X	X	X	X	105	108	111	114	114
HALF	Three Years	117	117	119	119	121	123	125	126	127	128	129	129
MILE	Four Years	130	130	130	130	130	130	130	130	130	130	130	130
	Five Years and Up	130	130	130	130	130	130	130	130	130	130	130	130
	Two Years	X	X	X	X	X	X	X	102	105	108	111	111
SIX	Three Years	114	114	117	117	119	121	123	125	126	127	128	128
FURLONGS	Four Years	129	129	130	130	130	130	130	130	130	130	130	130
	Five Years and Up	130	130	130	130	130	130	130	130	130	130	130	130
	Two Years	X	X	X	X	X	X	X	X	96	99	102	102
ONE	Three Years	107	107	111	111	113	115	117	119	121	122	123	123
MILE	Four Years	127	127	128	128	127	126	126	126	126	126	126	126
	Five Years and Up	128	128	128	128	127	126	126	126	126	126	126	126
	Two Years	X	X	X	X	X	X	X	X	X	X	X	X
MILE AND	Three Years	101	101	107	107	111	113	116	118	120	121	122	122
A QUARTER	Four Years	125	125	127	127	127	126	126	126	126	126	126	126
	Five Years and Up	127	127	127	127	127	126	126	126	126	126	126	126
	Two Years	X	X	X	X	X	X	X	X	X	X	X	X
MILE AND	Three Years	98	98	104	104	108	111	114	117	119	121	122	122
A HALF	Four Years	124	124	126	126	126	126	126	126	126	126	126	126
	Five Years and Up	126	126	126	126	126	126	126	126	126	126	126	126
	Two Years	X	X	X	X	X	X	X	X	X	X	X	X
TWO MILES	Three Years	96	96	102	102	106	109	112	114	117	119	120	120
	Four Years	124	124	126	126	126	126	126	125	125	124	124	124
	Five Years and Up	126	126	126	126	126	126	126	125	125	124	124	124

(2) Weights listed.

1. In races of intermediate lengths, the weights for the shorter distance shall be carried.
2. In a race exclusively for two-year-olds, the weight shall be 122 pounds.
3. In a race exclusively for three-year-olds or four-year-olds, the weight shall be 126 pounds.

(3) Minimum weight.

1. Thoroughbreds. In all overnight races for two-year-olds, three-year-olds, or four-year-olds and older, the minimum weight shall be 112 pounds, subject to sex and apprentice allowance. This rule shall not apply to handicaps or to races written for three-year-olds and older.

2. Quarter horse and mixed races. In all overnight races for two-year-olds, the weight shall be 120 pounds; for three-year-olds, the weight shall be 122 pounds; and for four-year-olds and older, the weight shall be 124 pounds.

3. Quarter horse and mixed races. In qualifying for a speed index, standard weight shall be 120 pounds. Should any horse carry less than this amount in a race, one-tenth of a second will be added to the official time for each four pounds or fraction thereof less than 120 pounds.

(4) Sex allowances. In thoroughbred racing, sex allowances are obligatory. Sex allowances shall be applied in all thoroughbred races unless the conditions of the race expressly state to the contrary. If the conditions of the race are silent as to sex allowances, a sex allowance shall be applied. Sex allowances may not be declined. Two-year-old fillies shall be allowed three pounds; mares three years old and older are allowed five pounds before September 1 and three pounds thereafter. Sex allowances are not applicable for quarter horse or mixed races.

h. Penalties not cumulative. Penalties and weight allowances are not cumulative unless so declared in the conditions of a race by the racing secretary.

i. Winnings.

(1) All inclusive. For the purpose of the setting of conditions by the racing secretary, winnings shall be considered to include all moneys and prizes won up to the time of the start of a race, including those races outside the United States. Foreign winnings shall be determined on the basis of the normal rate of exchange prevailing on the day of the win. The amount of purse money earned is credited in United States currency, and there shall be no appeal for any loss on the exchange rate at the time of transfer from United States currency to that of another country.

(2) Winnings considered from January 1. Winnings during the year shall be reckoned by the racing secretary from the preceding January 1.

(3) Winner of a certain sum. "Winner of a certain sum" means the winner of a single race of that sum, unless otherwise expressed in the condition book by the racing secretary. In determining the net value to the winner of any race, the sums contributed by its owner or nominator shall be deducted from the amount won. In all stakes races, the winnings shall be computed on the value of the gross earnings.

(4) Winner's award. Rescinded IAB 5/16/01, effective 6/20/01.

j. Cancellation of a race. The racing secretary has the authority to withdraw, cancel, or change any race which has not been closed. In the event the race is canceled, any and all fees paid in connection with the race shall be refunded.

k. Coggins test. The racing secretary shall ensure that all horses have a current negative Coggins test. The racing secretary shall report all expired certificates to the stewards.

l. Registrations and supporting documents. The racing secretary shall be responsible for receiving, inspecting, and safeguarding all registrations and supporting documents submitted by the trainer while the horses are located on facility premises. Upon notification from a trainer of an alteration of the sex of a horse, the racing secretary shall note such alteration on the certificate of registration. Disclosure is made for the benefit of the public and all documents pertaining to the ownership or lease of a horse filed with the racing secretary shall be available for public inspection.

10.4(6) *Paddock judge.*

a. General authority. The paddock judge shall:

(1) Supervise the assembly of horses in the paddock no later than 15 minutes before the scheduled post time for each race;

(2) Maintain a written record of all equipment, inspect all equipment of each horse saddled, and report any change thereof to the stewards;

(3) Prohibit any change of equipment without the approval of the stewards;

(4) Ensure that the saddling of all horses is orderly, open to public view, free from public interference, and that horses are mounted at the same time and leave the paddock for the post in proper sequence;

(5) Supervise paddock schooling of all horses approved for such by the stewards;

(6) Report to the stewards any observed cruelty to a horse; and

(7) Ensure that only properly authorized persons are permitted in the paddock.

b. Paddock judge's list.

(1) The paddock judge shall maintain a list of horses which shall not be entered in a race because of poor or inconsistent behavior in the paddock that endangers the health or safety of other participants in racing.

(2) At the end of each day, the paddock judge shall provide a copy of the list to the stewards.

(3) To be removed from the paddock judge's list, a horse must be schooled in the paddock and demonstrate to the satisfaction of the paddock judge and the stewards that the horse is capable of performing safely in the paddock.

10.4(7) *Horse identifier.* The horse identifier shall:

a. When required, ensure the safekeeping of registration certificates and racing permits for horses stabled or racing on facility premises;

b. Inspect documents of ownership, eligibility, registration, or breeding necessary to ensure the proper identification of each horse scheduled to compete at a race meeting;

c. Examine every starter in the paddock for sex, color, markings, and lip tattoo for comparison with its registration certificate to verify the horse's identity;

d. Supervise the tattooing or branding for identification of any horse located on facility premises; and

e. Report to the stewards any horse not properly identified or whose registration certificate is not in conformity with these rules.

10.4(8) *Starter.*

a. General authority. The starter shall:

(1) Have complete jurisdiction over the starting gate, the starting of horses, and the authority to give orders not in conflict with the rules as may be required to ensure all participants an equal opportunity to a fair start;

(2) Appoint and supervise assistant starters who have demonstrated they are adequately trained to safely handle horses in the starting gate. In emergency situations, the starter may appoint qualified individuals to act as substitute assistant starters;

(3) Assign the starting gate stall positions to assistant starters and notify the assistant starters of their respective stall positions more than ten minutes before post time for the race;

(4) Assess the ability of each person applying for a jockey's license in breaking from the starting gate and working a horse in the company of other horses, and make said assessment known to the stewards; and

(5) Load horses into the gate in any order deemed necessary to ensure a safe and fair start.

b. Assistant starters. With respect to an official race, the assistant starters shall not:

(1) Handle or take charge of any horse in the starting gate without the expressed permission of the starter;

(2) Impede the start of a race;

(3) Use excessive force, a whip or other device, with the exception of steward-approved tongs, to assist in loading a horse into the starting gate;

(4) Slap, boot, or otherwise dispatch a horse from the starting gate;

(5) Strike or use abusive language to a jockey; or

(6) Accept or solicit any gratuity or payment other than their regular salary, directly or indirectly, for services in starting a race.

c. Starter's list. No horse shall be permitted to start in a race unless approval is given by the starter. The starter shall maintain a starter's list of all horses which are ineligible to be entered in any race because of poor or inconsistent behavior or performance in the starting gate. Any horse on the starter's list shall be refused entry until the horse has demonstrated to the starter that it has been satisfactorily schooled in the gate and can be removed from the starter's list. Schooling shall be under the direct supervision of the starter.

10.4(9) *Timer/clocker.*

a. General authority—timer.

(1) The timer shall accurately record the official time.

(2) At the end of a race, the timer shall post the official running time on the infield totalizator board on instruction by the stewards.

(3) At a facility equipped with an appropriate infield totalizator board, the timer shall post the quarter times (splits) for thoroughbred races in fractions as a race is being run. For quarter horse races, the timer shall post the official times in hundredths of a second.

(4) For backup purposes, the timer shall also use a stopwatch to time all races. In time trials, the timer shall ensure that at least two stopwatches are used by the stewards or their representatives.

(5) The timer shall maintain, and make available for inspection by the stewards or the commission on request, a written record of fractional and finish times of each race.

b. General authority—clocker.

(1) The clocker shall be present during training hours at each track on facility premises which is open for training to identify each horse working out and to accurately record the distances and times of each horse's workout.

(2) Each day, the clocker shall prepare a list of workouts that includes the name of each horse which worked along with the distance and time of each horse's workout.

(3) At the conclusion of training hours, the clocker shall deliver a copy of the list of workouts to the stewards and the racing secretary.

10.4(10) *Placing judges.*

a. General authority. The placing judges shall determine the order of finish in a race as the horses pass the finish line and, with the approval of the stewards, may display the results on the totalizator board.

b. Photo finish.

(1) In the event the placing judges or the stewards request a photo of the finish, the photo finish sign shall be posted on the totalizator board.

(2) Following their review of the photo finish film strip, the placing judges shall, with the approval of the stewards, determine the exact order of finish for all horses participating in the race, and shall immediately post the numbers of the first four finishers on the totalizator board.

(3) In the event a photo was requested, the placing judges shall cause a photographic print of said finish to be produced. The finish photograph shall, when needed, be used by the placing judges as an aid in determining the correct order of finish.

(4) Upon determination of the correct order of finish of a race in which the placing judges have utilized a photographic print to determine the first four finishers, the placing judges shall cause prints of said photograph to be displayed publicly in the grandstand and clubhouse areas of the facility.

c. Dead heats.

(1) In the event the placing judges determine that two or more horses finished the race simultaneously and cannot be separated as to their order of finish, a dead heat shall, with the approval of the stewards, be declared.

(2) In the event one or more of the first four finishers of a race are involved in a dead heat, the placing judges shall post the dead heat sign on the totalizator board and cause the numbers of the horse or horses involved to blink on the totalizator board.

10.4(11) *Jockey room custodian.* The jockey room custodian shall:

a. Supervise the conduct of the jockeys and their attendants while they are in the jockey room;

b. Keep the jockey room clean and safe for all jockeys;

c. Ensure all jockeys are in the correct colors and wearing the correct arm number before leaving the jockey room to prepare for mounting their horses;

d. Keep a daily film list as dictated by the stewards and have it displayed in plain view for all jockeys;

e. Keep a daily program displayed in plain view for the jockeys;

f. Keep unauthorized persons out of the jockey room;

g. Report to the stewards any unusual occurrences in the jockey room;

h. Assist the clerk of scales as required;

i. Supervise the care and storage of racing colors; and

j. Assign to each jockey a locker for the use of storing the jockey's clothing, equipment, and personal effects.

10.4(12) *Mutuel manager.* The mutuel manager is responsible for the operation of the mutuel department. The mutuel manager shall ensure that any delays in the running of official races caused by totalizator malfunctions are reported to the stewards. The mutuel manager shall submit a written report on any delay when requested by the state steward.

10.4(13) *Clerk of scales.* The clerk of scales shall:

a. Verify the presence of all jockeys in the jockey room at the appointed time;

b. Verify that each jockey has a current jockey's license issued by the commission;

c. Verify the correct weight of each jockey at the time of weighing out and weighing in and report any discrepancies to the stewards immediately;

d. Oversee the security of the jockey room including the conduct of the jockeys and their attendants;

e. Record all required data on the scale sheet and submit that data to the horsemen's bookkeeper at the end of each race day;

f. Maintain the record of applicable winning races on all apprentice certificates at the meeting;

g. Release apprentice jockey certificates, upon the jockey's departure or upon the conclusion of the race meet; and

h. Assume the duties of the jockey room custodian in the absence of such employee.

10.4(14) *Outrider.*

a. The facility shall appoint a minimum of two outriders on the main track for each race of a performance and during workouts. The facility shall appoint one outrider on the training track during all workouts. The outriders must be neat in appearance, wear approved helmets with the chin straps securely fastened, and wear approved safety vests while on the main track or training track.

b. The outriders shall:

(1) Accompany the field of horses from the paddock to the post;

(2) Ensure the post parade is conducted in an orderly manner, with all jockeys and pony riders conducting themselves in a manner in conformity with the best interests of racing as determined by the board of stewards;

(3) Assist jockeys with unruly horses;

(4) Render assistance when requested by a jockey;

(5) Be present during morning workouts to assist exercise riders as required by regulations;

(6) Promptly report to the stewards any unusual conduct which occurs while performing the duties of an outrider;

(7) Ensure individuals using the track(s) are appropriately licensed; and

(8) Promptly report jockey objections to the stewards after the finish of each race.

10.4(15) *Horsemen's bookkeeper.*

a. General authority. The horsemen's bookkeeper shall maintain the records and accounts and perform the duties described herein and maintain such other records and accounts and perform such other duties as the facility and commission may prescribe.

b. Records.

(1) The records shall include the name, mailing address, social security number or federal tax identification number, and the state or country of residence of each horse owner, trainer, or jockey participating at the race meeting who has funds due or on deposit in the horsemen's account.

(2) The records shall include a file of all required statements of partnerships, syndicates, corporations, assignments of interest, lease agreements, and registrations of authorized agents.

(3) All records of the horsemen's bookkeeper shall be kept separate and apart from the records of the facility.

(4) All records of the horsemen's bookkeeper including records of accounts and moneys and funds kept on deposit are subject to inspection by the commission at any time.

c. Moneys and funds on account.

(1) All moneys and funds on account with the horsemen's bookkeeper shall be maintained:

1. Separate and apart from moneys and funds of the facility;

2. In a trust account designated as "horsemen's trust account"; and

3. In an account insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation.

(2) The horsemen's bookkeeper shall be bonded.

d. Payment of purses.

(1) The horsemen's bookkeeper shall receive, maintain, and disburse the purses of each race and all stakes, entrance money, jockey fees, purchase money in claiming races, all applicable taxes, and other moneys that properly come into the horsemen's bookkeeper's possession in accordance with the provisions of commission rules.

(2) The horsemen's bookkeeper may accept moneys due, belonging to other organizations or recognized meetings, provided prompt return is made to the organization to which the money is due.

(3) The horsemen's bookkeeper shall disburse the purse of each race and all stakes, entrance money, jockey fees, purchase money in claiming races, and all applicable taxes, upon request, within 48 hours of receipt of notification that all tests with respect to such races have cleared the drug testing laboratory (commission chemist) as reported by the stewards. Minimum jockey mount fees may be disbursed prior to notification that the tests have cleared the testing laboratory.

(4) Absent a prior request, the horsemen's bookkeeper shall disburse moneys to the persons entitled to receive same within 15 days after the last race day of the race meeting, including purses for official races, provided that all tests with respect to such races have cleared the drug testing laboratory as reported by the stewards, and provided further that no protest or appeal has been filed with the stewards or the commission.

(5) In the event a protest or appeal has been filed with the stewards or the commission, the horsemen's bookkeeper shall disburse the purse within 48 hours of receipt of dismissal or a final nonappealable order disposing of such protest or appeal.

e. No portion of purse money other than jockey fees shall be deducted by the facility for itself or for another, unless so requested in writing by the person to whom purse moneys are payable or the person's duly authorized representative. The horsemen's bookkeeper shall mail to each owner a duplicate of each record of all deposits, withdrawals, or transfers of funds affecting the owner's racing account at the close of each race meeting.

10.4(16) *Patrol judges.*

a. General authority. A facility may employ patrol judges who shall observe the running of the race and report information concerning the running of the race to the stewards.

b. Duty stations. Each patrol judge shall have a duty station assigned by the stewards.

10.4(17) *Commission veterinarians.*

a. The veterinarians shall advise the commission and the stewards on all veterinary matters.

b. The commission veterinarians shall have supervision and control of the detention barn for the collection of test samples for the testing of horses for prohibited medication as provided in Iowa Code sections 99D.23(2) and 99D.25(9). The commission may employ persons to assist the commission veterinarians in maintaining the detention barn area and collecting test samples.

c. The commission veterinarians shall not buy or sell any horse under their supervision; wager on a race under their supervision; or be licensed to participate in racing in any other capacity.

d. The stewards or commission veterinarians may request any horse entered in a race to undergo an examination on the day of the race to determine the general fitness of the horse for racing. During the examination, all bandages shall be removed by the groom upon request and the horse may be exercised outside the stall to permit the examiner to determine the condition of the horse's legs and feet. The examining veterinarian shall report any unsoundness in a horse to the stewards.

e. A commission veterinarian shall inspect all of the horses in a race at the starting gate and after the finish of a race shall observe the horses upon their leaving the track.

f. The commission veterinarian shall place any horse determined to be sick or too unsafe, unsound, or unfit to race on a veterinarian's list that shall be posted in a conspicuous place available to all owners, trainers, and officials.

g. A horse placed on the veterinarian's list, bleeders exempt, may be allowed to enter only after it has been removed from the list by the commission veterinarian. Requests for the removal of any horse from the veterinarian's list will be accepted only after three calendar days from the placing of the horse on the veterinarian's list have elapsed. Removal from the list will be at the discretion of the commission veterinarian, who may require satisfactory workouts or examinations to adequately demonstrate that the problem that caused the horse to be placed on the list has been rectified. Horses that are entered to race and then placed on the veterinarian's list for any reason will not be allowed to enter a race for a minimum of three calendar days beginning the day after the horse was scheduled to race.

Every confirmed bleeder, regardless of age, shall be placed on the bleeder list and be ineligible to race for the following time periods:

(1) First incident – 14 days.

(2) Second incident within 365-day period – 30 days.

(3) Third incident within 365-day period – 180 days.

(4) Fourth incident within 365-day period – barred for racing lifetime.

For the purposes of counting the number of days a horse is ineligible to run, the day the horse bled externally is the first day of the recovery period. The voluntary administration of furosemide without an external bleeding incident shall not subject the horse to the initial period of ineligibility specified in subparagraph (1). A horse may be removed from the bleeder list only upon the direction of the official veterinarian, who shall certify in writing to the stewards the recommendation for removal. A horse which has been placed on a bleeder list in another jurisdiction pursuant to these rules shall be placed on a bleeder list in this jurisdiction.

h. The commission veterinarians shall supervise and ensure that the administration of furosemide and phenylbutazone is in compliance with Iowa Code section 99D.25A.

i. Rescinded IAB 9/29/04, effective 11/3/04.

j. The commission veterinarian or commission representative shall take receipt of veterinary reports as required by Iowa Code section 99D.25(10).

491—10.5(99D) Trainer, jockey, and jockey agent responsibilities.

10.5(1) *Trainer.*

a. Responsibility. The trainer is responsible for:

(1) The condition of horses entered in an official workout or race and, in the absence of substantial evidence to the contrary, for the presence of any prohibited drug, medication or other substance, including permitted medication in excess of the maximum allowable level, in such horses, regardless of the acts of third parties. A positive test for a prohibited drug, medication, or substance, including permitted medication in excess of the maximum allowable level, as reported by a commission-approved laboratory, is prima facie evidence of a violation of this rule or Iowa Code chapter 99D.

(2) Preventing the administration of any drug, medication, or other prohibited substance that may cause a violation of these rules.

(3) Any violation of rules regarding a claimed horse's participation in the race in which the trainer's horse is claimed.

(4) The condition and contents of stalls, tack rooms, feed rooms, sleeping rooms, and other areas which have been assigned to the trainer by the facility and maintaining the assigned stable area in a clean, neat, and sanitary condition at all times.

(5) Ensuring that fire prevention rules are strictly observed in the assigned stable area.

(6) Being present to witness the administration of furosemide during the administration time and sign as the witness on the affidavit form. A licensed designee of the trainer may witness the administration of the furosemide and sign as the witness on the affidavit form; however, this designee may not be another practicing veterinarian or veterinary assistant.

(7) The proper identity, custody, care, health, condition, and safety of horses in the trainer's charge.

(8) Disclosure to the racing secretary of the true and entire ownership of each horse in the trainer's care, custody, or control. Any change in ownership shall be reported immediately to, and approved by, the stewards and recorded by the racing secretary. The disclosure, together with all written agreements

and affidavits setting out oral agreements pertaining to the ownership for or rights in and to a horse, shall be attached to the registration certificate for the horse and filed with the racing secretary.

(9) Training all horses owned wholly or in part by the trainer which are participating at the race meeting.

(10) Registering with the racing secretary each horse in the trainer's charge within 24 hours of the horse's arrival on facility premises.

(11) Ensuring that, at the time of arrival at the facility, each horse in the trainer's care is accompanied by a valid health certificate which shall be filed with the racing secretary.

(12) Having each horse in the trainer's care that is racing or stabled on facility premises tested for equine infectious anemia (EIA) in accordance with state law and for filing evidence of such negative test results with the racing secretary. The test must have been conducted within the previous 12 months and must be repeated upon expiration. The certificate must be attached to the foal certificate.

(13) Using the services of those veterinarians licensed by the commission to attend horses that are on facility premises.

(14) Immediately reporting the alteration of the sex of a horse in the trainer's care to the horse identifier and the racing secretary.

(15) Promptly reporting to the racing secretary and the commission veterinarian any horse on which a posterior digital neurectomy (heel nerving) has been performed and ensuring that such fact is designated on its certificate of registration. See Iowa Code subsections 99D.25(1) to 99D.25(3).

(16) Promptly reporting to the stewards and the commission veterinarian the serious illness of any horse in the trainer's charge.

(17) Promptly reporting the death of any horse in the trainer's care on facility premises to the stewards, owner, and the commission veterinarian and complying with Iowa Code subsection 99D.25(5) governing postmortem examination.

(18) Maintaining a knowledge of the medication record and status of all horses in the trainer's care.

(19) Immediately reporting to the stewards and the commission veterinarian if the trainer knows, or has cause to believe, that a horse in the trainer's custody, care, or control has received any prohibited drugs or medication.

(20) Representing an owner in making entries and scratches and in all other matters pertaining to racing.

(21) Eligibility of horses entered and weight or other allowance claimed.

(22) Ensuring the fitness of a horse to perform creditably at the distance entered.

(23) Ensuring that the trainer's horses are properly shod, bandaged, and equipped.

(24) Presenting the trainer's horse in the paddock at least 20 minutes before post time or at a time otherwise appointed before the race in which the horse is entered.

(25) Personally attending to the trainer's horses in the paddock and supervising the saddling thereof, unless excused by the stewards.

(26) Instructing the jockey to give the jockey's best effort during a race and instructing the jockey that each horse shall be ridden to win.

(27) Witnessing the collection of a urine or blood sample from the horse in the trainer's charge or delegating a licensed employee or the owner of the horse to do so.

(28) Notifying horse owners upon the revocation or suspension of the trainer's license. Upon application by the owner, the stewards may approve the transfer of such horses to the care of another licensed trainer and, upon such approved transfer, such horses may be entered to race.

b. Restrictions on wagering. A trainer with a horse(s) entered in a race shall be allowed to wager only on that horse(s) or that horse(s) in combination with other horses.

c. Assistant trainers.

(1) Upon the demonstration of a valid need, a trainer may employ an assistant trainer as approved by the stewards. The assistant trainer shall be licensed prior to acting in such capacity on behalf of the trainer.

(2) Qualifications for obtaining an assistant trainer's license shall be prescribed by the stewards and the commission and may include requirements set forth in 491—Chapter 6.

(3) An assistant trainer may substitute for and shall assume the same duties, responsibilities and restrictions as are imposed on the licensed trainer, in which case the trainer shall be jointly responsible for the assistant trainer's compliance with the rules.

d. Substitute trainers.

(1) A trainer absent for more than five days from responsibility as a licensed trainer, or on a day in which the trainer has a horse in a race, shall obtain another licensed trainer to substitute.

(2) A substitute trainer shall accept responsibility for the horses in writing and shall be approved by the stewards.

(3) A substitute trainer and the absent trainer shall be jointly responsible as absolute insurers of the condition of their horses entered in an official workout or race.

10.5(2) *Jockey.*

a. Responsibility.

(1) A jockey shall give a best effort during a race, and each horse shall be ridden to win.

(2) A jockey shall not have a valet attendant except one provided and compensated by the facility.

(3) No person other than the licensed contract employer or a licensed jockey agent may make riding engagements for a rider, except that a jockey not represented by a jockey agent may make the jockey's own riding engagements.

(4) A jockey shall have no more than one jockey agent.

(5) No revocation of a jockey agent's authority is effective until the jockey notifies the stewards in writing of the revocation of the jockey agent's authority.

(6) A jockey shall promptly report objections to the outrider(s) following the finish of the race.

b. Jockey betting. A jockey shall be allowed to wager only on a race in which the jockey is riding. A jockey shall be allowed to wager only if:

(1) The owner or trainer of the horse that the jockey is riding makes the wager for the jockey;

(2) The jockey only wagers on the jockey's own mount to win or finish first in combination with other horses in multiple-type wagers; and

(3) Records of such wagers are kept and available for presentation upon request by the stewards.

c. Jockey's spouse. A jockey shall not compete in any race against a horse that is trained or owned by the jockey's spouse.

d. Jockey mount fees. Rescinded IAB 5/6/09, effective 6/10/09.

e. Entitlement. Any apprentice or contract rider shall be entitled to the regular jockey fees, except when riding a horse owned in part or solely by the contract holder. An interest in the winnings only (such as trainer's percent) shall not constitute ownership.

f. Fee earned. A jockey's fee shall be considered earned when the jockey is weighed out by the clerk of scales. The fee shall not be considered earned when injury to the horse or rider is not involved and jockeys, of their own free will, take themselves off their mounts. Any conditions or considerations not covered by the above shall be at the discretion of the stewards.

g. Multiple engagements. If any owner or trainer engages two or more jockeys for the same race, the owner or trainer shall be required to pay each of the jockeys the appropriate fee whether the jockeys ride in the race or not.

h. Dead heats. Jockeys finishing a race in a dead heat shall divide equally the totals they individually would have received had one jockey won the race alone. The owners of the horses finishing in the dead heat shall pay equal shares of the jockey fees.

i. Apprentices subject to jockey rules. Unless excepted under these rules, apprentices are subject to all rules governing jockeys and racing.

j. Conduct.

(1) Clothing and appearance. A jockey shall wear the colors furnished by the owner or facility with the number on the saddlecloth corresponding to the number given in the racing program. A jockey shall maintain a neat and clean appearance while engaged in duties on facility premises and shall wear a clean jockey costume, cap, helmet (approved by commission), a jacket of silk or waterproof fabric, breeches, and top boots.

(2) Competing against contractor. No jockey may ride in any race against a starting horse belonging to the jockey's contract employer unless the jockey's mount and the contract employer's horse are both trained by the same trainer.

(3) Confined to jockey room. Jockeys engaged to ride a race shall report to the jockey room on the day of the race at the time designated by the facility officials. The jockeys shall then report their engagements and any overweight to the clerk of scales. Thereafter, they shall not leave the jockey room, except by permission of the stewards, until all of their riding engagements of the day have been fulfilled. Once jockeys have fulfilled their riding engagements for the day and have left the jockeys' quarters, they shall not be readmitted to the jockeys' quarters until after the entire racing program for that day has been completed, except upon permission of the stewards. Jockeys are not allowed to communicate with anyone but the trainer while in the room during the performance except with approval of the stewards. On these occasions, they shall be accompanied by a security guard.

(4) Whip prohibited. Jockeys may not use a whip on a two-year-old horse before April 1 of each year, nor shall a jockey or other person engage in excessive or indiscriminate whipping of any horse at any time.

(5) Spurs prohibited. Jockeys shall not use spurs.

(6) Possessing drugs or devices. Jockeys shall not have in their care, control, or custody any drugs, prohibited substances, or electrical or mechanical device that could affect a horse's racing performance.

k. Jockey effort. A jockey shall exert every effort to ride the horse to the finish in the best and fastest run of which the horse is capable. No jockey shall ease up or coast to a finish, without adequate cause, even if the horse has no apparent chance to win prize money.

l. Duty to fulfill engagements. Jockeys shall fulfill their duly scheduled riding engagements, unless excused by the stewards. Jockeys shall not be forced to ride a horse they believe to be unsound or over a racing strip they believe to be unsafe. If the stewards find a jockey's refusal to fulfill a riding engagement is based on personal belief unwarranted by the facts and circumstances, the jockey may be subject to disciplinary action. Jockeys shall be responsible to their agent for any engagements previously secured by the agent.

m. Riding interference.

(1) When the way is clear in a race, a horse may be ridden to any part of the course; but if any horse swerves, or is ridden to either side, so as to interfere with, impede, or intimidate any other horse, it is a foul.

(2) The offending horse may be disqualified if, in the opinion of the stewards, the foul altered the finish of the race, regardless of whether the foul was accidental, willful, or the result of careless riding.

(3) If the stewards determine the foul was intentional, or due to careless riding, the jockey shall be held responsible.

(4) In a straightaway race, every horse must maintain position as nearly as possible in the lane in which it started. If a horse is ridden, drifts, or swerves out of its lane in such a manner that it interferes with, impedes, or intimidates another horse, it is a foul and may result in the disqualification of the offending horse.

n. Jostling. Jockeys shall not jostle another horse or jockey. Jockeys shall not strike another horse or jockey or ride so carelessly as to cause injury or possible injury to another horse in the race.

o. Partial fault/third-party interference. If a horse or jockey interferes with or jostles another horse, the aggressor may be disqualified, unless the interfered or jostled horse or jockey was partly at fault or the infraction was wholly caused by the fault of some other horse or jockey.

p. Careless riding. A jockey shall not ride carelessly or willfully permit the mount to interfere with, intimidate, or impede any other horse in the race. A jockey shall not strike at another horse or jockey so as to impede, interfere with, or injure the other horse or jockey. If a jockey rides in a manner contrary to this rule, the horse may be disqualified; or the jockey may be fined, suspended, or otherwise disciplined; or other penalties may apply.

q. Jockey weighed out.

(1) Jockeys must be weighed for their assigned horse not more than 30 minutes before the time fixed for the race.

(2) A jockey's weight shall include the jockey's clothing, boots, saddle and its attachments. A safety vest shall be mandatory, shall weigh no more than two pounds, and shall be designed to provide shock-absorbing protection to the upper body of at least a rating of five as defined by the British Equestrian Trade Association.

(3) All other equipment shall be excluded from the weight.

r. Overweight limited. No jockey may weigh more than two pounds or, in the case of inclement weather, four pounds over the weight the horse is assigned to carry unless with consent of the owner or trainer and unless the jockey has declared the amount of overweight to the clerk of scales at least 45 minutes before the time of the race. However, a horse shall not carry more than seven pounds overweight, except in inclement weather when nine pounds shall be allowed. The overweight shall be publicly announced and posted in a conspicuous place both prior to the first race of the day and before the running of the race.

(1) Weigh in. Upon completion of a race, jockeys shall ride promptly to the winner's circle and dismount. Jockeys riding the first four finishers, or at the discretion of the stewards a greater number, shall present themselves to the clerk of scales to be weighed in. If a jockey is prevented from riding the mount to the winner's circle because of accident or illness either to the jockey or the horse, the jockey may walk or be carried to the scales unless excused by the stewards.

(2) Unsaddling. Jockeys, upon completion of a race, must return to the unsaddling area and unsaddle their own horse, unless excused by the stewards.

(3) Removing horse's equipment. No person except the valet attendant for each mount is permitted to assist the jockey in removing the horse's equipment that is included in the jockey's weight, unless the stewards permit otherwise. To weigh in, jockeys shall carry to the scales all pieces of equipment with which they weighed out. Thereafter they may hand the equipment to the valet attendant.

(4) Underweight. When any horse places first, second, or third in a race, or is coupled in any form of multiple exotic wagering, and thereafter the horse's jockey is weighed in short by more than two pounds of the weight of which the jockey was weighed out, the mount may be disqualified and all purse moneys forfeited.

(5) Overweight. If the jockey is overweight, the jockey is subject to fine, suspension, or both.

s. Contracts. Rescinded IAB 5/16/01, effective 6/20/01.

t. Jockey fines and forfeitures. Jockeys shall pay any fine or forfeiture from their own funds within 48 hours of the imposition of the fine or at a time deemed proper by the stewards. No other person shall pay jockey fines or forfeitures for the jockey.

u. Competing claims. Whenever two or more licensees claim the services of one jockey for a race, first call shall have priority and any dispute shall be resolved by the stewards.

v. Jockey suspension.

(1) Offenses involving fraud. Suspension of a licensee for an offense involving fraud or deception in racing shall begin immediately after the ruling unless otherwise ordered by the stewards or commission.

(2) Offenses not involving fraud. Suspension for an offense not involving fraud or deception in racing shall begin on the third day after the ruling or at the stewards' discretion.

(3) Withdrawal of appeal. Withdrawal by the appellant of a notice of appeal filed with the commission, whenever imposition of the disciplinary action has been stayed or enjoined pending a final decision by the commission, shall be deemed a frivolous appeal and referred to the commission for further disciplinary action in the event the appellant fails to show good cause to the stewards why the withdrawal should not be deemed frivolous.

(4) Riding suspensions of ten days or less and participating in designated races. The stewards appointed for a race meeting shall immediately, prior to the commencement of that meeting, designate the stakes, futurities, futurity trials, or other races in which a jockey will be permitted to compete, notwithstanding the fact that such jockey is technically under suspension for ten days or less for a riding infraction at the time the designated race is to be run.

1. Official rulings for riding suspensions of ten days or less shall state: "The term of this suspension shall not prohibit participation in designated races."

2. A listing of the designated races shall be posted in the jockey room and any other such location deemed appropriate by the stewards.

3. A suspended jockey must be named at time of entry to participate in any designated race.

4. A day in which a jockey participated in one designated race while on suspension shall count as a suspension day. If a jockey rides in more than one designated race on a race card while on suspension, the day shall not count as a suspension day. Designated trials for a stake shall be considered one race.

10.5(3) *Apprentice jockey.* Upon completion of licensing requirements, the stewards may issue an apprentice jockey certificate allowing the holder to claim this allowance only in overnight races.

a. An apprentice jockey shall ride with a five-pound weight allowance beginning with the first mount and for one full year from the date of the jockey's fifth winning mount.

b. If, after riding one full year from the date of the fifth winning mount, the apprentice jockey has not ridden 40 winners, the applicable weight allowance shall continue for one more year or until the fortieth winner, whichever comes first. In no event shall a weight allowance be claimed for more than two years from the date of the fifth winning mount, unless an extension has been granted.

c. The steward may extend the weight allowance of an apprentice jockey when, in the discretion of the steward, the apprentice provides proof of incapacitation for a period of seven or more consecutive days. The allowance may be claimed for a period not to exceed the period such apprentice was unable to ride.

d. The apprentice jockey must have the apprentice certificate with the jockey at all times and must keep an updated record of the first 40 winners. Prior to riding, the jockey must submit the certificate to the clerk of scales, who will record the apprentice's winning mounts.

10.5(4) *Jockey agent.*

a. Responsibilities.

(1) A jockey agent shall not make or assist in making engagements for a jockey other than the jockeys the agent is licensed to represent.

(2) A jockey agent shall file written proof of all agencies and changes of agencies with the stewards.

(3) A jockey agent shall notify the stewards, in writing, prior to withdrawing from representation of a jockey and shall submit to the stewards a list of any unfulfilled engagements made for the jockey.

(4) All persons permitted to make riding engagements shall maintain current and accurate records of all engagements made. Such records shall be subject to examination by the stewards at any time.

(5) A jockey agent may represent an apprentice jockey and two journeymen jockeys or three journeymen jockeys at a "mixed" meet. However, at the "mixed" meeting two, at most, may ride the same breed.

(6) A jockey agent must honor a first call given to a trainer or the trainer's assistant trainer.

b. Prohibited areas. A jockey agent is prohibited from entering the jockey room, winner's circle, racing strip, paddock, or saddling enclosure during the hours of racing.

c. A jockey agent shall not be permitted to withdraw from the representation of any jockey unless written notice to the stewards has been provided.

[**ARC 7757B**, IAB 5/6/09, effective 6/10/09]

491—10.6(99D) Conduct of races.

10.6(1) Horses ineligible. Any horse ineligible to be entered for a race, or ineligible to start in any race, which competes in that race may be disqualified and the stewards may discipline the persons responsible for the horse competing in that race.

a. A horse is ineligible to enter a race when:

(1) The nominator has failed to identify the horse which is being entered for the first time, by name, color, sex, age, and the names of sire and dam as registered.

(2) A horse has been knowingly entered or raced in any jurisdiction under a different name, with an altered registration certificate, or altered lip tattoo by a person having lawful custody or control of the horse for the purpose of deceiving any facility or regulatory agency.

(3) A horse has been allowed to enter or start by a person having lawful custody or control of the horse who participated in or assisted in the entry or racing of some other horse under the name of the horse in question.

(4) A horse is wholly or partially owned by a disqualified person or a horse is under the direct or indirect management of a disqualified person.

(5) A horse is wholly or partially owned by the spouse of a disqualified person or a horse is under the direct or indirect management of the spouse of a disqualified person. In such cases, a presumption which may be rebutted is that the disqualified person and spouse constitute a single financial entity with respect to the horse.

(6) A horse is owned in whole or in part by an undisclosed person or interest.

(7) A horse has been nerved by surgical neurectomy.

(8) A horse has been trachea-tubed to artificially assist breathing.

(9) A horse has impaired eyesight in both eyes.

(10) A horse appears on the starter's list, stewards' list, paddock list, or veterinarian's list, notwithstanding a horse appearing on the veterinarian's list as a "bleeder."

(11) A horse is barred from racing in any racing jurisdiction.

b. A horse is ineligible to start a race when:

(1) The horse is not stabled on the premises of the facility by the time designated by the stewards.

(2) The horse's breed registration certificate is not on file with the racing secretary, or horse identifier, except in the case of a quarter horse where the racing secretary has submitted the certificate to the breed registry for correction. The stewards may, in their discretion, waive the requirement in nonclaiming races provided the horse is otherwise properly identified.

(3) The horse is not fully identified by an official tattoo on the inside of the upper lip.

(4) A horse is brought to the paddock and is not in the care of and saddled by a currently licensed trainer or assistant trainer.

(5) No current negative Coggins test or current negative equine infectious anemia test certificate is attached to the horse's registration certificate.

(6) The stakes or entrance money for the horse has not been paid.

(7) The horse appears on the starter's list, stewards' list, paddock list, or veterinarian's list.

(8) The horse is a first-time starter not approved by the starter and does not have a minimum of two published workouts.

(9) Within the past calendar year, the horse has started in a race that has not been reported in a nationally published monthly chartbook, unless, at least 48 hours prior to entry, the owner of the horse provides to the racing secretary performance records which show the place and date of the race, distance, weight carried, amount carried, and the horse's finishing position and time.

(10) In a stakes race, a horse has been transferred with its engagements, unless prior to the start, the fact of transfer of the horse and its engagements has been filed with the racing secretary.

(11) A horse is subject to a lien which has not been approved by the stewards and filed with the horsemen's bookkeeper.

(12) A horse is subject to a lease not filed with the stewards.

(13) A horse is not in sound racing condition.

(14) A horse has been blocked with alcohol or injected with any other foreign substance or drug to desensitize the nerves of the leg.

(15) A horse appears on the veterinarian's list as a "bleeder."

10.6(2) Entries.

a. The facility shall provide forms for making entries and declarations with the racing secretary. Entries and declarations shall be in writing, or by telephone or fax subsequently confirmed in writing by the owner, trainer, or authorized agent. When any entrant or nominator claims failure or error in the receipt by a facility of any entry or declaration, the entrant or nominator may be required to submit evidence within a reasonable time of the filing of the entry or the declaration.

b. Upon the closing of entries the racing secretary shall promptly compile a list of entries and cause it to be conspicuously posted.

c. Coupling.

(1) Entry coupling. When one owner or lessee enters more than one horse in the same race or a horse trained by a trainer who owns or leases any interest in any of the other horses in the race, the horses shall be coupled as an entry, except that entries may be uncoupled in stakes races. Horses shall be regarded as having a common owner when an owner of one horse, either as an individual, a licensed member of a partnership, or a licensed shareholder of a corporation, has an aggregate commonality of ownership of 5 percent interest in another horse, either as an individual, a licensed member of a partnership, or a licensed shareholder of a corporation.

(2) Coupled entry limitations on owner. No more than two horses coupled by a common ownership or trainer shall be entered in an overnight race.

(3) Coupling of entries by stewards. The stewards may couple as a single entry any horses which, in the determination of the stewards, are connected by common ownership, common lessee, the same trainer, or when the stewards determine that coupling is necessary in the interest of the regulation of the pari-mutuel wagering industry or is necessary to ensure the public's confidence in racing.

(4) Exclusion of single interest. Horses having the same owner, lessee, or trainer shall not be permitted to enter or start if the effect would deprive a single interest from starting in overnight races.

d. Split or divided races.

(1) In the event a race is canceled or declared off, the facility may split any overnight race for which post positions have not been drawn.

(2) Where an overnight race is split, forming two or more separate races, the racing secretary shall give notice of not less than 15 minutes before such races are closed to grant time for making additional entries to such split race.

e. Entry weight. Owners, trainers, or any other duly authorized person who enters a horse for a race shall ensure that the entry is correct and accurate as to the weight allowances available and claimed for the horse under the conditions set for the race. After a horse is entered and has been assigned a weight to carry in the race, the assignment of weight shall not be changed except in the case of error and with the approval of the stewards. Weight allowances may be waived with the approval of the stewards.

f. Consecutive days. No horse shall be run on two consecutive calendar days.

g. Foreign entries. For the purposes of determining eligibility, weight assignments, or allowances for horses imported from a foreign nation, the racing secretary shall take into account the "Pattern Race Book" published jointly by the Irish Turf Club, The Jockey Club of Great Britain, and the Société d'Encouragement.

h. Weight conversions. For the purpose of determining eligibility, weight assignments, or allowances for horses imported from a foreign nation, the racing secretary shall convert metric distances to English measures by reference to the following scale:

1 sixteenth	= 100 meters
1 furlong	= 200 meters
1 mile	= 1600 meters

i. Name. The "name" of a horse means the name reflected on the certificate of registration, racing permit, or temporary racing permit issued by the breed registry. Imported horses shall have a suffix, enclosed by brackets, added to their registered names showing the country of foaling. This suffix is derived from the international code of suffixes and constitutes part of the horse's registered name. The registered names and suffixes, where applicable, shall be printed in the official program.

j. Bona fide entry. No person shall enter or attempt to enter a horse for a race unless that entry is a bona fide entry, made with the intention that the horse is to compete in the race for which the horse was entered.

k. Registration certificate to reflect correct ownership. Every breed registry foal certificate filed with the racing secretary to establish the eligibility of a horse to be entered for any race shall accurately reflect the correct and true ownership of the horse. The name of the owner that is printed on the official

program for the horse shall conform to the ownership as declared on the certificate of registration or eligibility certificate unless a stable name has been registered with the commission for the owner or ownership.

l. Naming/engaging of riders. Riders must be named at the time of entry. Before naming any rider, the trainer, owner, or other person authorized must first engage the services of the rider and state on the entry or to the person taking the entry whether it is a first or second call, excluding trial races. Riders properly engaged must fulfill their engagements as required in 10.5(2)*"l."*

m. More than one race. No horse may be entered in more than one race, with the exception of stakes races, to be run on the same day on which pari-mutuel wagering is conducted.

10.6(3) Sweepstakes entries.

a. Entry and withdrawal. The entry of a horse in a sweepstakes is a subscription to the sweepstakes. Before the time of closing, any entry or subscription may be altered or withdrawn.

b. Entrance money. Entrance money shall be paid by the nominator to a race. In the event of the death of the horse or a mistake made in the entry of an otherwise eligible horse, the nominator subscriber shall continue to be obligated for any stakes, and the entrance money shall not be returned.

c. Quarter horse scratches and qualifiers unable to participate in finals. If a horse should be scratched from the time trial finals, the horse's owner will not be eligible for a refund of the fees paid. If a horse that qualified for the final should be unable to enter due to racing soundness, or scratched for any reason other than a positive drug test report or a rule violation, the horse shall be deemed to have earned and the owner will receive last place money. If more than one horse should be unable to enter due to racing soundness, or scratched for any reason other than a positive drug test report or a rule violation, then those purse moneys shall be added together and divided equally among the horse owners.

10.6(4) Closing of entries.

a. Overnight entries. Entries for overnight racing shall be closed at 10 a.m. by the racing secretary, unless a later closing is established by the racing secretary or unless approved by the stewards.

b. Sweepstakes entries. If an hour for closing is designated, entries and declarations for sweepstakes cannot be received thereafter. However, if a time for closing is not designated, entries and declarations may be mailed or faxed until midnight of the day of closing, if they are received in time to comply with all other conditions of the race. In the absence of notice to the contrary, entries and declarations for sweepstakes that close during or on the day preceding a race meeting shall close at the office of the racing secretary in accordance with any requirements the secretary shall make. Closing for sweepstakes not during race meetings shall be at the office of the facility.

c. Exception. Nominations for stakes races shall not close nor shall any eligibility payment be due on a day in which the United States Postal Service is not operating.

10.6(5) Prohibited entries.

a. Entry by disqualified person. An entry made by a disqualified person or the entry of a disqualified horse shall be void. Any money paid for the entry shall be returned, if the disqualification is disclosed at least 45 minutes before post time for the race. Otherwise, the entry money shall be paid to the winner.

b. Limited partner entry prohibited. No person other than a managing partner of a limited partnership or a person authorized by the managing partner may enter a horse owned by that partnership.

c. Altering entries prohibited. No alteration shall be made in any entry after the closing of entries, but the stewards may permit the correction of an error in an entry.

d. Limitation on overnight entries. If the number of entries to any purse or overnight race is in excess of the number of horses that may be accommodated due to the size of the track, the starters for the race and their post positions shall be determined by lot conducted in public by the racing secretary.

e. Stake race entry limit. In a stake race, the number of horses which may compete shall be limited only by the number of horses nominated and entered. In any case, the facility's lawful race conditions shall govern.

f. Stewards' denial of entry. The stewards may, after notice to the entrant, subscriber, or nominator, deny entry of any horse to a race if the stewards determine the entry to be in violation of

these rules or the laws of this state or to be contrary to the interests of the commission in the regulation of pari-mutuel wagering or to public confidence in racing.

10.6(6) Preferences and eligibles.

a. Also eligible. A list of not more than eight names may be drawn from entries filed in excess of positions available in the race. These names shall be listed as "also eligible" to be used as entries if originally entered horses are withdrawn. Any owner, trainer, or authorized agent who has entered a horse listed as an "also eligible" and who does not wish to start shall file a scratch card with the secretary not later than the scratch time designated for that race. "Also eligibles" shall have preference to scratch.

b. Preference system. A system using dates or stars shall be used to determine preference for horses being entered in races. The system being used will be at the option of the racing secretary and approved by the stewards. A preference list will be kept current by the racing secretary and made available to horsemen upon request.

c. Disputed decision. When the decision of a race is in dispute, all horses involved in the dispute, with respect to the winner's credit or earnings, shall be liable to all weights or conditions attached to the winning of that race until a winner has been finally adjudged.

10.6(7) Post positions. Post positions shall be determined by the racing secretary publicly and by lot. Post positions shall be drawn from "also eligible" entries at scratch time. In all races, horses drawn into the race from the "also eligible" list shall take the outside post positions, except in straightaway quarter horse racing. In straightaway quarter horse racing, the post position of the scratched horse shall be assigned to the horse "drawing in." In the event there is more than one scratch, the post positions shall be assigned by lot.

10.6(8) Scratch; declaring out.

a. Notification to the secretary. No horse shall be considered scratched, declared out, or withdrawn from a race until the owner, agent, or other authorized person has given notice in writing to the racing secretary before the time set by the facility as scratch time. All scratches must be approved by the stewards.

b. Declaration irrevocable. Scratching or the declaration of a horse out of an engagement for a race is irrevocable.

c. Limitation on scratches. No horse shall be permitted to be scratched from a race if the horses remaining in the race number fewer than eight, unless the stewards permit a lesser number. When the number of requests to scratch would, if granted, leave a field of fewer than eight, the stewards shall determine by lot which entrants may be scratched and permitted to withdraw from the race.

d. Scratch time. Unless otherwise set by the stewards, scratch time shall be:

(1) Stakes races. Scratch time shall be at least 45 minutes before post time.

(2) Other races. Scratch time shall be no later than 10 a.m. of the day of the race.

10.6(9) Workouts.

a. When required. No horse shall be allowed to start unless the horse has raced in an official race or has an approved official timed workout satisfactory to the stewards. A horse that has not started for a period of 60 days or more shall be ineligible to race until it has completed a published workout satisfactory to the stewards prior to the day of the race in which the horse is entered. The workout must have occurred within the previous 30 days for a thoroughbred or within the previous 60 days for a quarter horse. First-time starters must have at least two published workouts and be approved from the gate by the starter.

b. Identification. The timer or the stewards may require licensees to identify a horse in their care being worked. The owner, trainer, or jockey may be required to identify the distance the horse is to be worked and the point on the track where the workout will start.

c. Information dissemination. If the stewards approve the timed workout so as to permit the horse to run in a race, they shall make it mandatory that this information be furnished to the public in advance of the race including, but not limited to, the following means:

(1) Announcement over the facility's public address system;

(2) Transmission on the facility's message board;

(3) Posting in designated conspicuous places in the racing enclosure; and

(4) Exhibit on track TV monitors at certain intervals if the track has closed circuit TV. If the workout is published prior to the race in either the Daily Racing Form or the track program, then it shall not be necessary to make the announcements set forth above.

d. Restrictions. No horse shall be taken onto the track for training or a workout except during hours designated by the facility.

10.6(10) Equipment.

a. Whip and bridle limitations. Unless permitted by the stewards, no whip or substitute for a whip shall exceed one pound or 30 inches and no bridle shall exceed two pounds.

b. Equipment change. No licensee may change the equipment used on a horse from that used in the horse's last race, unless with permission of the stewards. No licensee may add blinkers to a horse's equipment or discontinue their use without the prior approval of the starter and the stewards. In the paddock prior to a race, a horse's tongue may be tied down with clean bandages, clean gauze, or with a tongue strap.

10.6(11) Racing numbers.

a. Number display. Each horse in a race shall carry a conspicuous saddle cloth number corresponding to the official number given that horse on the official program.

b. Coupled entries. In the case of a coupled or other entry that includes more than one horse, each horse in the entry shall carry the same number, with a different distinguishing letter following the number. As an example, two horses in the same entry shall be entered as 1 and 1-A.

c. Field horses. In a combined field of horses, each horse in the field shall carry a separate number.

10.6(12) Valuation of purse money. Rescinded IAB 5/16/01, effective 6/20/01.

10.6(13) Dead heats.

a. When two horses run a dead heat for first place, all purses or prizes to which first and second horses would have been entitled shall be divided equally between them; and this applies in dividing all purses or prizes whatever the number of horses running a dead heat and whatever places for which the dead heat is run.

b. In the event of a dead-heat finish for second place and thereafter, when an objection to the winner of the race is sustained, the horses in the dead heat shall be considered to have run a dead heat for first place.

c. If a prize includes a cup, plate, or other indivisible prize, owners shall draw lots for the prize in the presence of at least two stewards.

10.6(14) The facility shall not make distribution of any purses until given clearance of chemical tests by the state steward.

10.6(15) Purse money presumption. The fact that purse money has been distributed prior to the issuance of a laboratory report shall not be deemed a finding that no chemical substance has been administered, in violation of these rules, to the horse earning the purse money.

10.6(16) Equine infectious anemia (EIA) test.

a. Certificate required. No horse shall be allowed to start or be stabled on the premises of the facility unless a valid negative Coggins test or other laboratory-approved negative EIA test certificate is on file with the racing secretary.

b. Trainer responsibility. In the event of claims, sales, or transfers, it shall be the responsibility of the new trainer to ascertain the validity of the certificate for the horse within 24 hours. If the certificate is either unavailable or invalid, the previous trainer shall be responsible for any reasonable cost associated with obtaining a negative EIA laboratory certificate.

c. Positive test reports. Whenever any owner or trainer is furnished a positive Coggins test or positive EIA test result, the horse shall be removed by the owner or trainer from facility premises or approved farms within 24 hours of actual notice to the owner or trainer of the infection.

10.6(17) Race procedures.

a. Full weight. Each horse shall carry the full weight assigned for that race from the paddock to the starting point, and shall parade past the stewards' stand, unless excused by the stewards.

b. Touching and dismounting prohibited. After the horses enter the track, jockeys may not dismount or entrust their horse to the care of an attendant unless due to an accident occurring to the

jockey, the horse, or the equipment, and then only with the prior consent of the starter. During any delay during which a jockey is permitted to dismount, all other jockeys may dismount and their horses may be attended by others. After the horses enter the track, only the hands of the jockey, the starter, the assistant starter, the commission veterinarian, an outrider on a lead pony, or persons approved by the stewards may touch the horse before the start of the race. If a horse throws its jockey on the way from the paddock to the post, the horse must be returned to the point where the jockey was thrown, where the horse shall be remounted and then proceed over the route of the parade to the post. The horse must carry its assigned weight from paddock to post and from post to finish.

c. Jockey injury. If a jockey is seriously injured on the way to the post, the horse shall be returned to the paddock, a replacement jockey obtained, and both the injured jockey and the replacement jockey will be paid by the owner.

d. Twelve-minute parade limit. After entering the track, all horses shall proceed to the starting post in not more than 12 minutes unless approved by the stewards. After passing the stewards' stand in parade, the horses may break formation and proceed to the post in any manner. Once at the post, the horses shall be started without unnecessary delay. All horses must participate in the parade carrying their weight and equipment from the paddock to the starting post, and any horse failing to do so may be disqualified by the stewards. No lead pony leading a horse in the parade shall obstruct the public's view of the horse being led except with permission of the stewards.

e. Striking a horse prohibited. In assisting the start of a race, no person other than the jockey, starter, assistant starter, or veterinarian shall strike a horse or use any other means to assist the start.

f. Loading of horses. Horses will be loaded into the starting gate in numerical order or in any other fair and consistent manner determined by the starter and approved by the stewards.

g. Delays prohibited. No person shall obstruct or delay the movement of a horse to the starting post.

10.6(18) Claiming races.

a. Eligibility.

(1) Registered to race or open claim. No person may file a claim for any horse unless the person:

1. Is a licensed owner at the meeting who either has foal paper(s) registered with the racing secretary's office or has started a horse at the meeting; or

2. Is a licensed authorized agent, authorized to claim for an owner eligible to claim; or

3. Has a valid open claim certificate. Any person not licensed as an owner, or a licensed authorized agent for the account of the same, or a licensed owner not having foal paper(s) registered with the racing secretary's office or who has not started a horse at the meeting may request an open claim certificate from the commission. The person must submit a completed application for a prospective owner's license to the commission. The applicant must have the name of the trainer licensed by the commission who will be responsible for the claimed horse. A nonrefundable fee must accompany the application along with any financial information requested by the commission. The names of the prospective owners shall be prominently displayed in the offices of the commission and the racing secretary. The application will be processed by the commission; and when the open claim certificate is exercised, an owner's license will be issued.

(2) One stable claim. No stable that consists of horses owned by more than one person and which has a single trainer may submit more than one claim in any race. An authorized agent may submit only one claim in any race regardless of the number of owners represented.

b. Procedure for claiming. To make a claim for a horse, an eligible person shall:

(1) Deposit to the person's account with the horsemen's bookkeeper the full claiming price and applicable taxes as established by the racing secretary's conditions.

(2) File in a locked claim box maintained for that purpose by the stewards the claim filled out completely in writing and with sufficient accuracy to identify the claim on forms provided by the facility at least ten minutes before the time of the race.

c. Claim box.

(1) The claim box shall be approved by the commission and kept locked until ten minutes prior to the start of the race, when it shall be presented to the stewards or their representatives for opening and publication of the claims.

(2) The claim box shall also include a time clock which automatically stamps the time on the claim envelope prior to its being dropped in the box.

(3) No official of a facility shall give any information as to the filing of claims therein until after the race has been run.

d. Claim irrevocable. After a claim has been filed in the claim box, it shall not be withdrawn.

e. Multiple claims on single horses. If more than one claim is filed on a horse, the successful claim shall be determined by lot conducted by the stewards or their representatives.

f. Successful claims; later races.

(1) Sale or transfer. No successful claimant may sell or transfer a horse, except in a claiming race, for a period of 30 days from the date of claim.

(2) Eligibility price. A horse that is declared the official winner in the race in which it is claimed may not start in a race in which the claiming price is less than the amount for which it was claimed. After the first start back or 30 days, whichever occurs first, a horse may start for any claiming price. A horse which is not the official winner in the race in which it is claimed may start for any claiming price. This provision shall not apply to starter handicaps in which the weight to be carried is assigned by the handicapper. No right, title, or interest for any claimed horse shall be sold or transferred except in a claiming race for a period of 30 days following the date of claiming. The day claimed shall not count, but the following calendar day shall be the first day.

(3) Racing elsewhere. A horse that was claimed under these rules may not participate at a race meeting other than that at which it was claimed until the end of the meeting, except with written permission of the stewards. This limitation shall not apply to stakes races.

(4) Same management. A claimed horse shall not remain in the same stable or under the control or management of its former owner.

(5) When a horse is claimed out of a claiming race, the horse's engagements are included.

g. Transfer after claim.

(1) Forms. Upon a successful claim, the stewards shall issue in triplicate, upon forms approved by the commission, an authorization of transfer of the horse from the original owner to the claimant. Copies of the transfer authorization shall be forwarded to and maintained by the commission, the stewards, and the racing secretary. No claimed horse shall be delivered by the original owner to the successful claimant until authorized by the stewards. Every horse claimed shall race for the account of the original owner, but title to the horse shall be transferred to the claimant from the time the horse becomes a starter. The successful claimant shall become the owner of the horse at the time of starting, regardless of whether it is alive or dead, sound or unsound, or injured during the race or after it. The original trainer of the claimed horse shall be responsible for the postrace test results.

(2) Other jurisdiction rules. The commission will recognize and be governed by the rules of any other jurisdiction regulating title and claiming races when ownership of a horse is transferred or affected by a claiming race conducted in that other jurisdiction.

(3) Determination of sex and age. The claimant shall be responsible for determining the age and sex of the horse claimed notwithstanding any designation of sex and age appearing in the program or in any racing publication. In the event of a spayed mare, the (s) for spayed should appear next to the mare's name on the program. If it does not and the claimant finds that the mare is in fact spayed, claimant may then return the mare for full refund of the claiming price.

(4) Affidavit by claimant. The stewards may, if they determine it necessary, require any claimant to execute a sworn statement that the claimant is claiming the horse for the claimant's own account or as an authorized agent for a principal and not for any other person.

(5) Delivery required. No person shall refuse to deliver a properly claimed horse to the successful claimant. The claimed horse shall be disqualified from entering any race until delivery is made to the claimant.

(6) Obstructing rules of claiming. No person or licensee shall obstruct or interfere with another person or licensee in claiming any horse or enter into any agreement with another to subvert or defeat the object and procedures of a claiming race, or attempt to prevent any horse entered from being claimed.

h. Elimination of stable. An owner whose stable has been eliminated by claiming may claim for the remainder of the meeting at which eliminated or for 30 racing days, whichever is longer. With the permission of the stewards, stables eliminated by fire or other casualty may claim under this rule.

i. Deceptive claim. The stewards may cancel and disallow any claim within 24 hours after a race if they determine that a claim was made upon the basis of a lease, sale, or entry of a horse made for the purpose of fraudulently obtaining the privilege of making a claim. In the event of a disallowance, the stewards may further order the return of a horse to its original owner and the return of all claim moneys.

j. Protest of claim. A protest to any claim must be filed with the stewards before noon of the day following the date of the race in which the horse was claimed. Nonracing days are excluded from this rule.

k. Waived claiming rule.

(1) At the time of entry into claiming races, the owner, trainer, or any authorized agent may opt to declare a horse ineligible to be claimed provided:

1. The horse has not been an official starter at any racetrack for a minimum of 120 days since the horse's last race as an official starter (at time of race);
2. The horse's last race as an official starter was a claiming race in which the horse was eligible to be claimed;
3. The horse is entered for a claiming price equal to or greater than the claiming price at which the horse last started as an official starter;
4. Failure of declaration of ineligibility at time of entry may not be remedied; and
5. Ineligibility to be claimed shall apply only to the horse's first start as an official starter following each such 120-day or longer layoff.

(2) Any win which occurs in a claiming race by a horse ineligible to be claimed under waived claiming rules of this, or any other, jurisdiction will be treated as an allowance win for the determination of the horse's eligibility and allowances for every race at the meet, unless the conditions of the race specify otherwise.

10.6(19) Quarter horse time trial races.

a. Except in cases where the starting gate physically restricts the number of horses starting, each time trial shall consist of no more than ten horses.

b. The time trials shall be raced under the same conditions as the finals. If the time trials are conducted on the same day, the horses with the ten fastest times shall qualify to participate in the finals. If the time trials are conducted on two days, the horses with the five fastest times on the first day and the horses with the five fastest times on the second day shall qualify to participate in the finals. When time trials are conducted on two days, the racing office should make every attempt to split owners with more than one entry into separate days so that the owner's horses have a chance at all ten qualifying positions.

c. If the facility's starting gate has fewer than ten stalls, then the maximum number of qualifiers will correspond to the maximum number of starting gate post positions.

d. If only 11 or 12 horses are entered to run in time trials from a gate with 12 or more stalls, the facility may choose to run finals only. If 11 or 12 horses participate in the finals, only the first 10 finishers will receive purse money.

e. In the time trials, horses shall qualify on the basis of time and order of finish. The times of the horses in the time trial will be determined to the limit of the timer. The only exception is when two or more horses have the same time in the same trial heat. Then the order of finish shall also determine the preference in the horses' qualifying for the finals. Should two or more horses in different time trials have the same qualifying time to the limit of the timer for the final qualifying position(s), then a draw by public lot shall be conducted as directed by the stewards. Under no circumstances should stewards or placing judges attempt to determine horses' qualifying times in separate trials beyond the limit of the timer by comparing or enlarging a photo finish picture.

f. Except in the case of disqualification, under no circumstances shall a horse qualify ahead of a horse that finished ahead of that horse in the official order of finish in a time trial.

g. Should a horse be disqualified for interference during the running of a time trial, it shall receive the time of the horse it is immediately placed behind plus one hundredth of a second, or the maximum accuracy of the electronic timing device. No adjustments will be made in the times recorded in the time trials to account for headwind, tailwind, and off track. In the case where a horse is disqualified for interference with another horse causing loss of rider or the horse not to finish the race, the disqualified horse may be given no time plus one hundredth of a second, or the maximum accuracy of the electronic timing device.

h. Should a malfunction occur with an electronic timer on any time trial, finalists from that time trial will then be determined by official hand times operated by three official and disinterested persons. The average of the three hand times will be utilized for the winning time, unless one of the hand times is clearly incorrect. In such cases, the average of the two accurate hand times will be utilized for the winning time. The other horses in that race will be given times according to the order and margins of finish with the aid of the photo finish strip, if available.

i. When there is a malfunction of the timer during the time trials, but the timer operates correctly in other time trials, under no circumstances should the accurate electronic times be discarded and the average of the hand times used for all time trials. (The only exemption may be if the conditions of the stakes race so state, or state that, in the case of a malfunction of the timer in trials, finalists will be selected by order of finish in the trials.)

j. In the case where the accuracy of the electronic timer or the average of the hand times is questioned, the video of a time trial may be used to estimate the winning time by counting the number of video frames in the race from the moment the starting gate stall doors are fully open parallel to the racing track. This method is accurate to approximately .03 seconds. Should the case arise where the timer malfunctions and there are no hand times, the stewards have the option to select qualifiers based on the video time.

k. Should there be a malfunction of the starting gate and one or more stall doors not open or open after the exact moment when the starter dispatches the field, the stewards may declare the horses in stalls with malfunctioning doors to be nonstarters. The stewards should have the option, however, to allow any horse whose stall door opened late but still ran a time fast enough to qualify to be declared a starter for qualifying purposes. In the case where a horse breaks through the stall door or the stall door opens prior to the exact moment the starter dispatches the field, the horse must be declared a nonstarter and all entry fees refunded. In the case where one or more, but not all, stall doors open at the exact moment the starter dispatches the field, these horses should be considered starters for qualifying purposes, and placed according to their electronic times. If the electronic timer malfunctions in this instance, the average of the hand times, or, if not available, the video time, should be utilized for the horses that were declared starters.

l. There will be an also eligible list only in the case of a disqualification for a positive drug test report, ineligibility of the horse according to the conditions of the race, or a disqualification by the stewards for a rule violation. Should a horse be disqualified for a positive drug test report, ineligibility of the horse according to the conditions of the race, or a disqualification by the stewards for a rule violation, the next fastest qualifier shall assume the disqualified horse's position in the finals.

m. If a horse should be scratched from the time trials, the horse's owner will not be eligible for a refund of the fees paid, and that horse will not be allowed to enter the finals under any circumstances. If a horse that qualified for the finals is unable to enter due to racing soundness or is scratched for any reason other than a positive drug test report or a rule violation, the horse shall be deemed to have earned, and the owner will receive, last place purse money. If more than one horse if scratched from the finals for any reason other than a positive drug test report or a rule violation, then the purse moneys shall be added together and divided equally among the owners.

[**ARC 7757B**, IAB 5/6/09, effective 6/10/09; **ARC 9987B**, IAB 2/8/12, effective 3/14/12]

491—10.7(99D) Medication and administration, sample collection, chemists, and practicing veterinarian.

10.7(1) *Medication and administration.*

a. No horse, while participating in a race, shall carry in its body any medication, drug, foreign substance, or metabolic derivative thereof, which is a narcotic or which could serve as a local anesthetic or tranquilizer or which could stimulate or depress the circulatory, respiratory, or central nervous system of a horse, thereby affecting its speed.

b. Also prohibited are any drugs or foreign substances that might mask or screen the presence of the prohibited drugs, or prevent or delay testing procedures.

c. Proof of detection by the commission chemist of the presence of a medication, drug, foreign substance, or metabolic derivative thereof, prohibited by paragraph *"a"* or *"b,"* in a saliva, urine, or blood sample duly taken under the supervision of the commission veterinarian from a horse immediately prior to or promptly after running in a race shall be prima facie evidence that the horse was administered, with the intent that it would carry or that it did carry in its body while running in a race, prohibited medication, drug, or foreign substance in violation of this rule.

d. Administration or possession of drugs.

(1) No person shall administer, cause to be administered, or participate or attempt to participate in any way in the administration of any medication, drug, foreign substance, or treatment by any route to a horse registered for racing on the day of the race prior to the race in which the horse is entered.

(2) No person except a veterinarian shall have in the person's possession any prescription drug. However, a person may possess a noninjectable prescription drug for animal use if:

1. The person actually possesses, within the racetrack enclosure, documentary evidence that a prescription has been issued to said person for such a prescription drug.

2. The prescription contains a specific dosage for the particular horse or horses to be treated by the prescription drug.

3. The horse or horses named in the prescription are then in said person's care within the racetrack enclosure.

(3) No veterinarian or any other person shall have in their possession or administer to any horse within any racetrack enclosure any chemical or biological substance which:

1. Has not been approved for use on equines by the Food and Drug Administration pursuant to the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. Section 301 et seq., and implementing regulations, without the prior written approval from a commission veterinarian, after consulting with the board of stewards.

2. Is on any of the schedules of controlled substances as prepared by the Attorney General of the United States pursuant to 21 U.S.C. Sections 811 and 812, without the prior written approval from a commission veterinarian after consultation with the board of stewards. The commission veterinarian shall not give such approval unless the person seeking the approval can produce evidence in recognized veterinary journals or by recognized equine experts that such chemical substance has a beneficial therapeutic use in horses.

(4) No veterinarian or any other person shall dispense, sell, or furnish any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route, to any person within the premises of the facility unless there is a label specifying the name of the substance dispensed, the name of the dispensing person, the name of the horse or horses for which the substance is dispensed, the purpose for which said substance is dispensed, the dispensing veterinarian's recommendations for withdrawal before racing (if applicable), and the name of the person to whom dispensed, or is otherwise labeled as required by law.

(5) No person shall have in the person's possession or in areas under said person's responsibility on facility premises any feed supplement, tonic, veterinary preparation, medication, or any substance that can be administered or applied to a horse by any route unless it complies with the labeling requirements in 10.7(1)*"d"*(4).

e. Any person found to have administered, or caused, participated in, or attempted to participate in any way in the administration of a medication, drug, or foreign substance that caused or could have caused a violation of this rule shall be subject to disciplinary action.

f. The owner, trainer, groom, or any other person having charge, custody, or care of the horse is obligated to protect the horse properly and guard it against the administration or attempted administration of a substance in violation of this rule. If the stewards find that any person has failed to show proper protection and guarding of the horse, or if the stewards find that any owner, lessee, or trainer is guilty of negligence, they shall impose discipline and take other action they deem proper under any of the rules including referral to the commission.

g. In order for a horse to be placed on the bleeder list in Iowa through reciprocity, that horse must be certified as a bleeder in another state or jurisdiction. A certified bleeder is a horse that has raced with furosemide in another state or jurisdiction in compliance with the laws governing furosemide in that state or jurisdiction.

h. The possession or use of blood doping agents, including but not limited to those listed below, on the premises of a facility under the jurisdiction of the commission is forbidden:

(1) Erythropoietin;

(2) Darbepoetin;

(3) Oxyglobin®; and

(4) Hemopure®.

i. The use of extracorporeal shock wave therapy or radial pulse wave therapy shall not be permitted unless the following conditions are met:

(1) Any treated horse shall not be permitted to race for a minimum of ten days following treatment;

(2) The use of extracorporeal shock wave therapy or radial pulse wave therapy machines shall be limited to veterinarians licensed to practice by the commission;

(3) Any extracorporeal shock wave therapy or radial pulse wave therapy machines on the association grounds must be registered with and approved by the commission or its designee before use;

(4) All extracorporeal shock wave therapy or radial pulse wave therapy treatments must be reported to the official veterinarian on the prescribed form not later than the time prescribed by the official veterinarian.

j. The use of a nasogastric tube (a tube longer than six inches) for the administration of any substance within 24 hours prior to the post time of the race in which the horse is entered is prohibited without the prior permission of the official veterinarian or designee.

k. Non-steroidal anti-inflammatory drugs (NSAIDs).

(1) The use of one of three approved NSAIDs shall be permitted under the following conditions:

1. The level does not exceed the following permitted serum or plasma threshold concentrations which are consistent with administration by a single intravenous injection at least 24 hours before the post time for the race in which the horse is entered:

- Phenylbutazone (or its metabolite oxyphenylbutazone) – 5 micrograms per milliliter;
- Flunixin – 20 nanograms per milliliter;
- Ketoprofen – 10 nanograms per milliliter.

2. The NSAIDs listed in numbered paragraph "1" or any other NSAIDs are prohibited from being administered within the 24 hours before post time for the race in which the horse is entered.

3. The presence of more than one of the three approved NSAIDs, with the exception of phenylbutazone in a concentration below 1 microgram per milliliter of serum or plasma, or the presence of any unapproved NSAID in the post-race serum or plasma sample is not permitted. The use of all but one of the approved NSAIDs shall be discontinued at least 48 hours before the post time for the race in which the horse is entered.

(2) Any horse to which an NSAID has been administered shall be subject to having a blood sample(s), urine sample(s) or both taken at the direction of the official veterinarian to determine the quantitative NSAID level(s) or the presence of other drugs which may be present in the blood or urine sample(s).

10.7(2) *Sample collection.*

a. Under the supervision of the commission veterinarian, urine, blood, and other specimens shall be taken and tested from any horse that the stewards, commission veterinarian, or the commission's representatives may designate. The samples shall be collected by the commission veterinarian or other person or persons the commission may designate. Each sample shall be marked or numbered and bear information essential to its proper analysis; but the identity of the horse from which the sample was taken or the identity of its owners or trainer shall not be revealed to the official chemist or the staff of the chemist. The container of each sample shall be sealed as soon as the sample is placed therein.

b. A facility shall have a detention barn under the supervision of the commission veterinarian for the purpose of collecting body fluid samples for any tests required by the commission. The building, location, arrangement, furnishings, and facilities including refrigeration and hot and cold running water must be approved by the commission. A security guard, approved by the commission, must be in attendance at each access to the detention barn during the hours designated by the commission.

c. No unauthorized person shall be admitted at any time to the building or the area utilized for the purpose of collecting the required body fluid samples or the area designated for the retention of horses pending the obtaining of body fluid samples.

d. During the taking of samples from a horse, the owner, responsible trainer, or a representative designated by the owner or trainer may be present and witness the taking of the sample and so signify in writing. Failure to be present and witness the collection of the samples constitutes a waiver by the owner, trainer, or representative of any objections to the source and documentation of the sample.

e. The commission veterinarian, the board of stewards, agents of the division of criminal investigation, or commission representative may take samples of any medicine or other materials suspected of containing improper medication, drugs, or other substance which could affect the racing condition of a horse in a race, which may be found in barns or elsewhere on facility premises or in the possession of any person connected with racing, and the same shall be delivered to the official chemist for analysis.

f. Nothing in these rules shall be construed to prevent:

(1) Any horse in any race from being subjected by the order of a steward or the commission veterinarian to tests of body fluid samples for the purpose of determining the presence of any foreign substance.

(2) The state steward or the commission veterinarian from authorizing the splitting of any sample.

(3) The commission or commission veterinarian from requiring body fluid samples to be stored in a frozen state for future analysis.

g. Before leaving the racing surface, the trainer shall ascertain the testing status of the horse under the trainer's care from the commission veterinarian or designated detention barn representative.

10.7(3) *Chemists.*

a. Tests are to be under the supervision of the commission, which shall employ one or more chemists or contract with one or more qualified chemical laboratories to determine by chemical testing and analysis of body fluid samples whether a foreign substance, medication, drug or metabolic derivative thereof is present.

b. All body fluid samples taken by or under direction of the commission veterinarian or commission representative shall be delivered to the laboratory of the official chemist for analysis.

c. The commission chemist shall be responsible for safeguarding and testing each sample delivered to the laboratory by the commission veterinarian.

d. The commission chemist shall conduct individual tests on each sample, screening them for prohibited substances, and conducting other tests to detect and identify any suspected prohibited substance or metabolic derivative thereof with specificity. Pooling of samples shall be permitted only with the knowledge and approval of the commission.

e. Upon the finding of a test negative for prohibited substances, the remaining portions of the sample may be discarded. Upon the finding of tests suspicious or positive for prohibited substances, the tests shall be reconfirmed, and the remaining portion, if available, of the sample shall be preserved and protected for two years following close of meet.

f. The commission chemist shall submit to the commission a written report as to each sample tested, indicating by sample tag identification number, whether the sample was tested negative or positive for prohibited substances. The commission chemist shall report test findings to no person other than the administrator or commission representative, with the exception of notifying the state stewards of all positive tests.

g. In the event the commission chemist should find a sample suspicious for a prohibited medication, additional time for test analysis and confirmation may be requested.

h. In reporting to the state steward a finding of a test positive for a prohibited substance, the commission chemist shall present documentary or demonstrative evidence acceptable in the scientific community and admissible in court in support of the professional opinion as to the positive finding.

i. No action shall be taken by the state steward until an official report signed by the chemist properly identifying the medication, drug, or other substance as well as the horse from which the sample was taken has been received.

j. The cost of the testing and analysis shall be paid by the commission to the official chemist. The commission shall then be reimbursed by each facility on a per-sample basis so that each facility shall bear only its proportion of the total cost of testing and analysis. The commission may first receive payment from funds provided in Iowa Code chapter 99D, if available.

10.7(4) *Practicing veterinarian.*

a. Prohibited acts.

(1) Ownership. A licensed veterinarian practicing at any meeting is prohibited from possessing any ownership, directly or indirectly, in any racing animal racing during the meeting.

(2) Wagering. Veterinarians licensed by the commission as veterinarians are prohibited from placing any wager of money or other thing of value directly or indirectly on the outcome of any race conducted at the meeting at which the veterinarian is furnishing professional service.

(3) Prohibition of furnishing injectable materials. No veterinarian shall within the facility premises furnish, sell, or loan any hypodermic syringe, needle, or other injection device, or any drug, narcotic, or prohibited substance to any other person unless with written permission of the stewards.

b. The use of other than single-use disposable syringes and infusion tubes on facility premises is prohibited. Whenever a veterinarian has used a hypodermic needle or syringe, the veterinarian shall destroy the needle and syringe and remove the needle and syringe from the facility premises.

c. Veterinarians must submit daily to the commission veterinarian on a prescribed form a report of all procedures, medications and other substances which the veterinarian prescribed, administered, or dispensed for racing animals registered at the current race meeting as provided in Iowa Code section 99D.25(10). Reports shall be submitted not later than noon the day following the treatments' being reported. Reports shall include the racing animal, trainer, procedure, medication or other substance, dosage or quantity, route of administration, date and time administered, dispensed, or prescribed. Reports shall be signed by the practicing veterinarian.

d. Within 20 minutes following the administration of furosemide, the veterinarian must deliver to the commission veterinarian or commission representative a signed affidavit certifying information regarding the treatment of the horse. The statement must include, at a minimum, the name of the practicing veterinarian, the tattoo number of the horse, the location of the barn and stall where the treatment occurred, the race number of the horse, the name of the trainer, and the time that the furosemide was administered. This affidavit must be signed by the trainer or trainer's designee who witnessed the administration of furosemide. The veterinarian shall not administer the furosemide if a witness is not present. Furosemide shall only be administered (by a single intravenous injection) in a dose level allowed by Iowa Code section 99D.25A, subsection 7.

e. Each veterinarian shall report immediately to the commission veterinarian any illness presenting unusual or unknown symptoms in a racing animal entrusted into the veterinarian's care.

f. Practicing veterinarians may have employees licensed as veterinary assistants working under their direct supervision. Activities of these employees shall not include direct treatment or diagnosis of any animal. The practicing veterinarian must be present if a veterinary assistant is to have access

to injection devices or injectables. The practicing veterinarian shall assume all responsibility for a veterinary assistant.

g. Equine dentistry is considered a function of veterinary practice by the Iowa veterinary practice Act. Any dental procedures performed at the facility must be performed by a licensed veterinarian or a licensed veterinary assistant.

h. Unless approved by the commission veterinarian, veterinarians shall not have contact with an entered horse on race day except for the administration of furosemide.

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◊ Two or more ARCs

1 Effective date (1/4/89) of 10.4(14), 10.4(19)*"b"* and 10.6 delayed by the Administrative Rules Review Committee until January 9, 1989, at its December 13, 1988, meeting; effective date of January 4, 1989, delayed seventy days by this Committee at its January 5, 1989, meeting. Effective date delay lifted by the Committee at its February 13, 1989, meeting.

2 Effective date of 10.6(2)*"g"*(3) second paragraph delayed until adjournment of the 1997 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held October 8, 1996.

CHAPTER 11
GAMBLING GAMES

491—11.1(99F) Definitions.

"Administrator" means the administrator of the commission.

"Coin" means tokens, nickels, and quarters of legal tender.

"Commission" means the racing and gaming commission.

"Currency" means any coin or paper money of legal tender and paper forms of cashless wagering.

"Discount rate" means either the current prime rate as published in the Wall Street Journal or a blended rate computed by obtaining quotes for the purchase of qualified investments at least three times per month.

"Distributor's license" means a license issued by the administrator to any entity that sells, leases, or otherwise distributes gambling games or implements of gambling to any entity licensed to conduct gambling games pursuant to Iowa Code chapter 99F.

"Facility" means an entity licensed by the commission to conduct gaming operations in Iowa.

"Facility grounds" means all real property utilized by the facility in the conduct of its gaming activity, including the grandstand, concession stands, offices, parking lots, and any other areas under the jurisdiction of the commission.

"Gambling game" means any game of chance approved by the commission for wagering, including, but not limited to, gambling games authorized by this chapter.

"Government sponsored enterprise debt instrument" means a negotiable, senior, noncallable debt obligation issued by an agency of the United States or an entity sponsored by an agency of the United States that on the date of funding possesses an issuer credit rating equivalent to the highest investment grade rating given by Standard & Poor's or Moody's Investment Services.

"Implement of gambling" means any device or object determined by the administrator to directly or indirectly influence the outcome of a gambling game; collect wagering information while directly connected to a slot machine; or be integral to the conduct of a commission-authorized gambling game.

"Manufacturer's license" means a license issued by the administrator to any entity that assembles, fabricates, produces, or otherwise constructs a gambling game or implement of gambling used in the conduct of gambling games pursuant to Iowa Code chapter 99F.

"Present value" means the current value of a future payment or series of payments, discounted using the discount rate.

"Qualified investment" means an Iowa state issued debt instrument, a United States Treasury debt instrument or a government sponsored enterprise debt obligation.

"Reserve" means an account with an independent financial institution or brokerage firm consisting of cash and qualified investments used to satisfy periodic payments of prizes.

"Slot machine" means a mechanical or electronic gambling game device into which a player may deposit currency or forms of cashless wagering and from which certain numbers of credits are awarded when a particular configuration of symbols or events is displayed on the machine.

"Storage media" means EPROMs, ROMs, flash-ROMs, DVDs, CD-ROMs, compact flashes, hard drives and any other types of program storage device.

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491—11.2(99F) Conduct of all gambling games.

11.2(1) *Commission policy.* It is the policy of the commission to require that all facilities conduct gambling games in a manner suitable to protect the public health, safety, morals, good order, and general welfare of the state. Responsibility for the employment and maintenance of suitable methods of operation rests with the facility. Willful or persistent use or toleration of methods of operation deemed unsuitable in the sole discretion of the commission will constitute grounds for disciplinary action, up to and including license revocation.

11.2(2) *Activities prohibited.* A facility is expressly prohibited from the following activities:

a. Failing to conduct advertising and public relations activities in accordance with decency, dignity, good taste, and honesty.

b. Permitting persons who are visibly intoxicated to participate in gaming activity.

c. Failing to comply with or make provision for compliance with all federal, state, and local laws and rules pertaining to the operation of a facility including payment of license fees, withholding payroll taxes, and violations of alcoholic beverage laws or regulations.

d. Possessing, or permitting to remain in or upon any facility grounds, any associated gambling equipment which may have in any manner been marked, tampered with, or otherwise placed in a condition or operated in a manner which might affect the game and its payouts.

e. Permitting, if the facility was aware of, or should have been aware of, any cheating.

f. Possessing or permitting to remain in or upon any facility grounds, if the facility was aware of, or should have been aware of, any cheating device whatsoever; or conducting, carrying on, operating, or dealing any cheating or thieving game or device on the grounds.

g. Possessing or permitting to remain in or upon any facility grounds, if the facility was aware of, or should have been aware of, any gambling device which tends to alter the normal random selection of criteria which determines the results of the game or deceives the public in any way.

h. Failing to conduct gaming operations in accordance with proper standards of custom, decorum, and decency; or permitting any type of conduct that reflects negatively on the state or acts as a detriment to the gaming industry.

i. Denying a commissioner or commission representative, upon proper and lawful demand, information or access to inspect any portion of the gaming operation.

11.2(3) *Gambling aids.* No person shall use, or possess with the intent to use, any calculator, computer, or other electronic, electrical, or mechanical device that:

a. Assists in projecting the outcome of a game.

b. Keeps track of cards that have been dealt.

c. Keeps track of changing probabilities.

11.2(4) *Wagers.* Wagers may only be made:

a. By a person present at a facility.

b. In the form of chips, coins, or other cashless wagering.

c. By persons 21 years of age or older.

[**ARC 8029B**, IAB 8/12/09, effective 9/16/09]

491—11.3(99F) Gambling games approved by the commission. The commission may approve a gambling game by administrative rule, resolution, or motion.

491—11.4(99F) Approval for distribution, operation, or movement of gambling games and implements of gambling.

11.4(1) *Approval.* Prior to distribution, a distributor shall request that the administrator inspect, investigate, and approve a gambling game or implement of gambling for compliance with commission rules and the standards required by a commission-designated independent testing facility. The distributor, at its own expense, must provide the administrator and independent testing facility with information and product sufficient to determine the integrity and security of the product, including independent testing conducted by a designated testing facility. The commission shall designate up to two independent testing facilities for the purpose of certifying electronic gambling games or implements of gambling.

11.4(2) *Trial period.* Prior to or after commission approval and after completing a review of a proposed gambling game, the administrator may require a trial period of up to 180 days to test the gambling game in a facility. During the trial period, minor changes in the operation or design of the gambling game may be made with prior approval of the administrator. During the trial period, a gambling game distributor shall not be entitled to receive revenue of any kind from the operation of that gambling game.

11.4(3) *Gambling game submissions.* Prior to conducting a commission-authorized gambling game or for a trial period, a facility shall submit proposals for game rules, procedures, wagers, shuffling procedures, dealing procedures, cutting procedures, and payout odds. The gambling game submission, or requests for modification to an approved submission, shall be in writing and approved by the administrator or a commission representative prior to implementation.

11.4(4) *Public notice.* The public shall have access to the rules of play, payout schedules, and permitted wagering amounts. Signage shall be conspicuously posted on the gaming floor to direct patrons to the gaming floor area where this information can be viewed. All participants in all licensed gambling games are required to know and follow the rules of play. No forms of cheating shall be permitted.

11.4(5) *Operation.* Each gambling game shall operate and play in accordance with the representation made to the commission and the public at all times. The administrator or commission representative may order the withdrawal of any gambling game suspected of malfunction or misrepresentation, until all deficiencies are corrected. The administrator or commission representative may require additional testing by an independent testing facility at the expense of the licensee or distributor for the purpose of complying with this subrule.

11.4(6) *Distribution, movement and disposal.*

a. Any entity providing slot machines, gambling games or implements of gambling to a licensed facility must file written notice with the commission at least five calendar days prior to receipt by the facility. A licensed facility selling or an owner removing slot machines or gambling games from the facility must file written notice with the commission at least one day prior to removal. All methods of disposal for slot machines, gambling games or implements of gambling are subject to administrator approval. Notification by facsimile or electronic mail shall be considered written notice.

b. The administrator may approve licensee transfers of slot machines, gambling games, or implements of gambling among subsidiaries of the licensee's parent company.

[**ARC 8029B**, IAB 8/12/09, effective 9/16/09; **ARC 9018B**, IAB 8/25/10, effective 9/29/10]

491—11.5(99F) Gambling games authorized.

11.5(1) Craps, roulette, twenty-one (blackjack), baccarat, and poker are authorized as table games. The administrator is authorized to approve multiplayer electronic devices simulating these games, subject to the requirements of rule 491—11.4(99F) and subrule 11.5(3).

11.5(2) Slot machines, video poker, and other video games of chance, both progressive and nonprogressive, shall be allowed as slot machine games, subject to the administrator's approval of individual slot machine prototypes and game variations. For racetrack enclosures without a table games license, video machines which simulate table games of chance shall not be allowed.

11.5(3) The administrator is authorized to approve variations of approved gambling games and bonus features or progressive wagers associated with approved gambling games, subject to the requirements of rule 491—11.4(99F).

a. Features utilizing a controller or a system linked to gambling games that do not require direct monetary consideration and are not otherwise integrated within a slot machine game theme may be allowed as bonus features. Payouts from these bonus features may be included in winnings for the calculation of wagering tax adjusted gross receipts when the following conditions are met:

(1) The only allowable nonmonetary consideration to be expended by a participant shall be active participation in a gambling game with a bonus feature or use of a player's club card, or both.

(2) The actual bonus payout deductible in any month from all qualified system bonuses requiring no additional direct monetary consideration shall be:

1. No more than 2 percent of the coin-in for all slot machines linked to any system bonuses for that month, if slot machines linked to system bonuses exceed 20 percent of the total number of slot machines; or

2. No more than 3 percent of the coin-in for all slot machines linked to any system bonuses for that month, if slot machines linked to system bonuses are less than or equal to 20 percent of the total number of slot machines; or

3. No more than 3 percent of the amount wagered on the qualifying bets for all table games linked to any system bonus for that month.

(3) The probability of winning a system bonus award shall be the same for all persons participating in the bonus feature.

b. Noncashable credit payouts may be allowed as bonus feature payouts subject to the administrator's approval of individual accounting, expiration and redemption practices.

11.5(4) Gambling games of chance involving prizes awarded to participants through promotional activities at a facility.

a. Proposals. Gambling games of chance involving prizes awarded to participants through promotional activities occurring at a facility shall be authorized and approved by the commission. Before a facility may conduct such gambling games, all proposals for terms, game rules, prizes, dates of operation and procedures for any gambling games of chance involving prizes awarded through promotional activities occurring at a facility shall be submitted in writing to a commission representative for approval. The written submission shall be submitted to the commission representative at least 14 days in advance of the planned activity. Any changes to an approved gambling game of chance involving prizes awarded to participants through promotional activities shall also require the approval of the commission representative. Gambling games of chance involving prizes awarded to participants through promotional activities occurring at a facility shall meet the following requirements:

(1) All rules of play shall be in writing and posted for public inspection;

(2) Such games shall be limited to participants 21 years of age or older;

(3) All games shall be conducted in a fair and honest manner, and all prizes advertised shall be awarded in accordance with the posted rules of play;

(4) All such games shall be conducted within the regulated area of the facility and shall be conducted in accordance with the submission approved by the commission representative;

(5) No entry fees shall be permitted; and

(6) All employees of the facility shall be prohibited from participation.

b. Limits. Gambling games of chance involving prizes awarded to participants through promotional activities conducted at a facility shall be subject to the wagering tax pursuant to Iowa Code section 99F.11. However, in determining the adjusted gross receipts, the facility may consider all nonmonetary consideration expended by a participant and shall certify to the commission that the nonmonetary consideration is at least equal to the value of the prizes awarded.

[**ARC 8029B**, IAB 8/12/09, effective 9/16/09; **ARC 9018B**, IAB 8/25/10, effective 9/29/10; **ARC 9987B**, IAB 2/8/12, effective 3/14/12]

491—11.6(99F) Gambling game-based tournaments.

11.6(1) *Proposals.* Proposals for terms, game rules, entry fees, prizes, dates, and procedures must be submitted in writing and approved by a commission representative before a facility conducts any tournament. Any changes to approved tournaments must be submitted to the commission representative for review and approval prior to being implemented. The written proposal or change shall be submitted to a commission representative at least 14 days in advance of the planned activity. Rules, fees, and a schedule of prizes must be made available to the player prior to entry.

11.6(2) *Limits.* Tournaments must be based on gambling games authorized by the commission. Entry fees, less prizes paid, are subject to the wagering tax pursuant to Iowa Code section 99F.11. In determining adjusted gross receipts, to the extent that prizes paid out exceed entry fees received, the facility shall be deemed to have paid the fees for the participants.

11.6(3) *Tournament chips.* Tournament chips used as wagers in table game tournament proposals approved pursuant to this rule shall be imprinted with a number representing the value of the chip or shall be assigned a value. The facility shall provide that:

a. The assigned value of tournament chips be conspicuously displayed in the tournament area.

b. Internal controls which account for all tournament chips and include reconciliation, handling and variance procedures are approved by a commission representative.

[**ARC 8029B**, IAB 8/12/09, effective 9/16/09; **ARC 9987B**, IAB 2/8/12, effective 3/14/12]

491—11.7(99F) Table game requirements.

11.7(1) Removable storage media in a table game device which controls the randomness of card shufflers or progressive table game meters shall be verified and sealed with evidence tape by a commission representative prior to implementation.

11.7(2) Wagers. All wagers at table games shall be made by placing gaming chips or coins on the appropriate areas of the layout. Information pertaining to the minimum and maximum allowed at the table shall be posted on the game. Any other fee collected to participate in a table game shall be subject to the wagering tax pursuant to Iowa Code section 99F.11.

11.7(3) Craps.

a. Wagers must be made before the dice are thrown. "Call bets," or the calling out of bets between the time the dice leave the shooter's hand and the time the dice come to rest, not accompanied by the placement of gaming chips, are not allowed. A wager made on any bet may be removed or reduced at any time prior to a roll that decides the outcome of such wager unless the wager is a "Pass" or "Come" bet and a point has been established with respect to such bet or the wager is a proposition bet contingent on multiple rolls.

b. The shooter shall make a "Pass" or "Don't Pass" bet and shall handle the two selected dice with one hand before throwing the dice in a simultaneous manner.

c. Each die used shall be transparent.

11.7(4) Twenty-one.

a. Before the first card is dealt for each round of play, each player shall make a wager against the dealer. Once the first card of any hand has been dealt by the dealer, no player shall handle, remove, or alter any wagers that have been made until a decision has been rendered and implemented with respect to that wager. Once a wager on the insurance line, a wager to double down, or a wager to split pairs has been made and confirmed by the dealer, no player shall handle, remove, or alter the wagers until a decision has been rendered and implemented with respect to that wager, except as explicitly permitted. A facility or licensee shall not permit any player to engage in conduct that violates this paragraph.

b. At the conclusion of a round of play, all cards still remaining on the layout shall be picked up by the dealer in a prescribed order and in such a way that they can be readily arranged to indicate each player's hand in case of question or dispute. The dealer shall pick up the cards beginning with those of the player to the far right and moving counterclockwise around the table. The dealer's hand will be the last hand collected. The cards will then be placed on top of the discard pile. No player or spectator shall remove or alter any cards used to game at twenty-one or be permitted to do so by a casino employee.

c. Each player at the table shall be responsible for correctly computing the point count of the player's hand. No player shall rely on the point counts announced by the dealer without checking the accuracy of such announcement.

11.7(5) Roulette.

a. No person at a roulette table shall be issued or permitted to game with nonvalue gaming chips that are identical in color and design to value gaming chips or to nonvalue gaming chips being used by another person at that same table.

b. Each player shall be responsible for the correct positioning of the player's wager on the roulette layout, regardless of whether the player is assisted by the dealer. Each player must ensure that any instructions the player gives to the dealer regarding the placement of the player's wager are correctly carried out.

c. Each wager shall be settled strictly in accordance with its position on the layout when the ball falls to rest in a compartment of the wheel.

11.7(6) Big six—roulette. Rescinded IAB 2/8/12, effective 3/14/12.

11.7(7) Poker.

a. When a facility conducts poker with an imprest dealer gaming chip bank, the rules in 491—Chapter 12 for closing and distributing or removing gaming chips to or from gaming tables do not apply. The entire amount of the table rake is subject to the wagering tax pursuant to Iowa Code section 99F.11. Proposals for imprest dealer gaming chip banks must be submitted in writing and approved by

a commission representative prior to use and must include, but not be limited to, controls to regularly monitor, investigate, and report table bank variances.

b. All games shall be played according to table stakes game rules as follows:

(1) Only gaming chips or coins on the table at the start of a deal shall be in play for that pot.

(2) Concealed gaming chips or coins shall not play.

(3) A player with gaming chips may add additional gaming chips between deals, provided that the player complies with any minimum buy-in requirement.

(4) A player is never obliged to drop out of contention because of insufficient gaming chips to call the full amount of a bet, but may call for the amount of gaming chips the player has on the table. The excess part of the bet made by other players is either returned to the players or used to form a side pot.

c. Each player in a poker game is required to act only in the player's own best interest. The facility has the responsibility of ensuring that any behavior designed to assist one player over another is prohibited. The facility may prohibit any two players from playing in the same game.

d. Poker games where winning wagers are paid by the facility according to specific payout odds or pay tables are permitted.

e. The facility shall comply with and receive approval pursuant to subrule 11.4(3) for each type of poker game offered.

f. The facility may elect to offer a jackpot award generated from pot contributions at a table or group of tables for predesignated high-value poker hands, subject to the following requirements:

(1) Approval of the jackpot award rules must be obtained from a commission representative prior to play.

(2) Jackpot award rules and jackpot award amounts shall be posted in a conspicuous location within the poker room. Jackpot award amounts shall be updated no less than once per day.

(3) The facility shall divide pot contributions for any single qualifying award circumstance or event into no more than three jackpot award pools.

(4) The jackpot award pool containing the highest monetary value amount shall be the amount posted in the poker room and awarded to a qualifying player or players.

(5) If additional jackpot award pools are in use, the award pool containing the highest monetary value shall be used to seed the primary jackpot award pool.

(6) All moneys collected as pot contributions to a jackpot award payout shall be distributed in their entirety to the players; no facility shall charge an administration fee for distribution of a jackpot award.

11.7(8) Baccarat. Before the first card is dealt for each round of play, each player is permitted to make a wager on the Banker's Hand, Player's Hand, Tie Bet, and any proposition bet if offered. All wagers shall be made by placing gaming chips on the appropriate areas of the layout. Once the first card has been dealt by the dealer, no player shall handle, remove, or alter any wagers that have been made until a decision has been rendered and implemented with respect to that wager.

[**ARC 9987B**, IAB 2/8/12, effective 3/14/12]

491—11.8(99F) Keno.

11.8(1) Keno shall be conducted using an automated ticket writing and redemption system where a game's winning numbers are selected by a random number generator.

11.8(2) Each game shall consist of the selection of 20 numbers out of 80 possible numbers, 1 through 80.

11.8(3) For any type of wager offered, the payout must be at least 70 percent.

11.8(4) Multigame tickets shall be limited to 20 games.

11.8(5) Writing or voiding tickets for a game after that game has closed is prohibited.

11.8(6) All winning tickets shall be valid up to a maximum of one year from the date of purchase. All expired, unclaimed winning tickets shall be subject to the requirements in 491—paragraph 12.11(2)*"b."*

11.8(7) The administrator shall determine minimum hardware and software requirements to ensure the integrity of play. An automated keno system must be proven to accurately account for adjusted gross receipts to the satisfaction of the administrator.

11.8(8) Adjusted gross receipts from keno games shall be the difference between dollar value of tickets written and dollar value of winning tickets as determined from the automated keno system. The wagering tax pursuant to Iowa Code section 99F.11 shall apply to adjusted gross receipts of keno games.

11.8(9) An area of a facility shall not be designated as gaming floor for the sole purpose of keno runners, who accept patron wagering funds remotely from the keno game location.

[**ARC 9018B**, IAB 8/25/10, effective 9/29/10]

491—11.9(99F) Slot machine requirements.

11.9(1) *Payout percentage.* A slot machine game must meet the following maximum and minimum theoretical percentage payouts during the expected lifetime of the game.

a. A slot machine game's theoretical payout must be at least 80 percent and no more than 100 percent of the amount wagered. The theoretical payout percentage is determined using standard methods of probability theory. Slot machine games with a bonus feature that is available with varying payouts based on the player's ability shall be allowed if the difference between the minimum and maximum payout for all ability-based outcomes does not exceed a 4 percent contribution to the overall theoretical payout of the slot machine game.

b. A slot machine game shall have a probability of obtaining the highest single advertised payout, which must statistically occur at least once in 50 million games.

11.9(2) *Features.* Unless otherwise authorized by the administrator, each slot machine in a casino shall have the following features:

a. A casino number at least two inches in height permanently imprinted, affixed, or impressed on the outside of the machine so that the number may be observed by the surveillance camera.

b. A clear description displayed on the slot machine of any merchandise or thing of value offered as a payout including the cash equivalent value of the merchandise or thing of value offered, the dates the merchandise or thing of value will be offered if the facility establishes a time limit upon initially offering the merchandise or thing of value, and the availability or unavailability to the patron of the optional cash equivalent value. A cash equivalent value shall be at least 75 percent of the fair market value of the merchandise or thing of value offered.

c. Devices, equipment, features, and capabilities, as may be required by the commission, that are specific to each slot machine after the prototype model is approved by the commission.

11.9(3) *Storage media.* Hardware media devices which contain game functions or characteristics, including but not limited to pay tables and random number generators, shall be verified and sealed with evidence tape by a commission representative prior to being placed in operation, as determined by the administrator.

11.9(4) *Posting of the actual aggregate payout percentage.* The actual aggregate payout percentage to the nearest one-tenth of 1 percent (0.1%) of all slot machine games in operation during the preceding three calendar months shall be posted at the main casino entrance, cashier cages, and slot booths by the fifteenth day of each calendar month. For the purpose of this calculation, the actual aggregate payout percentage shall be the slot revenue reported to the commission during the preceding three calendar months divided by the slot coin-in reported to the commission during the preceding three calendar months subtracted from 100 percent.

11.9(5) *Communication equipment.* Equipment must be installed in each slot machine that allows for communication to an online monitoring and control system accessible, with read-only access, to the commission representatives using a communications protocol provided to each licensed manufacturer by the commission for the information and control programs approved by the administrator.

11.9(6) *Meter clears.* Prior to the clearing of electronic accounting meters detailed in paragraph 11.10(2)*"c,"* a licensee must notify a commission representative. All meters recorded by the game must be retained according to the requirements in 491—subrule 5.4(14).

[**ARC 8029B**, IAB 8/12/09, effective 9/16/09; **ARC 9018B**, IAB 8/25/10, effective 9/29/10]

491—11.10(99F) Slot machine hardware and software specifications.

11.10(1) *Hardware specifications.*

a. Electrical and mechanical parts and design principles shall not subject players to physical hazards.

b. The battery backup, or an equivalent, for the electronic meters must be capable of maintaining accuracy of all required information for 30 days after power is discontinued from a slot machine. The backup shall be kept within the locked logic board compartment.

c. An identification badge permanently affixed by the manufacturer to the exterior of the cabinet shall include the following information:

(1) The manufacturer;

(2) A unique serial number;

(3) The gaming device model number; and

(4) The date of manufacture.

d. The operations and outcomes of each slot machine must not be adversely affected by influences from outside the device.

e. The internal space of a slot machine shall not be readily accessible when the front door is both closed and locked.

f. Logic boards and software storage media which significantly influence the operation of the game must be in a locked compartment within the slot machine.

g. The currency drop container must be in a locked compartment within or attached to the slot machine. Access to the currency storage areas shall be secured by separate locks which shall be fitted with sensors that indicate door open/closed or stacker removed.

h. No hardware switches may be installed that alter the pay tables or payout percentages in the operation of a slot machine. Hardware switches may be installed to control graphic routines, speed of play, and sound.

i. A display which automatically illuminates when a player has won a jackpot or other award not paid automatically and totally by the slot machine and which advises players that they will be paid by an attendant shall be located conspicuously on the slot machine.

j. A payglass/video display shall be clearly identified and shall accurately state the rules of the game and the award that will be paid to the player when the player obtains a specific combination of symbols or other criteria. All information required in this paragraph must be available and readable at all times the slot machine is in service.

k. A light that automatically illuminates when a player has won an amount or is redeeming credits that the machine cannot automatically pay, an error condition has occurred, or a "Call attendant" condition has been intitiated by the player shall be located conspicuously on top of the gaming device. At the discretion of the administrator, tower lights may be shared among certain machines or substituted by an audible alarm.

l. If credits are collected and the total credit value is unable to be paid automatically by the gaming device, the device shall lock up until the credits have been paid and the amount collected has been cleared by an attendant handpay or normal operation has been restored.

11.10(2) *Software specifications.*

a. Random number generator. Each slot machine must have a random number generator to determine the results of the game symbol selections or production of game outcomes. The selection shall:

(1) Be statistically independent.

(2) Conform to the desired random distribution.

(3) Pass various recognized statistical tests.

(4) Be unpredictable.

(5) Have a testing confidence level of 99 percent.

b. Continuation of game after malfunction is cleared. Each slot machine must be capable of continuing the current game with all current game features after a malfunction is cleared. This paragraph does not apply if a slot machine is rendered totally inoperable; however, the current wager and all credits appearing on the screen prior to the malfunction must be returned to the player.

c. Electronic accounting meters. Each slot machine must maintain electronic accounting meters at all times, regardless of whether the slot machine is being supplied with power. For each meter recording values, the slot machine must be capable of maintaining no fewer than ten digits. For each meter recording occurrences, the slot machine must be capable of maintaining no fewer than eight digits. No slot machine may have a mechanism that will cause the electronic accounting meters to automatically clear due to an error. The electronic meters must record, at a minimum, the following:

(1) Coin-in.
(2) Coin-out.
(3) Drop.
(4) Attendant-paid jackpots.
(5) Currency in.
(6) Currency out.
(7) External door.
(8) Bill validator door.
(9) Machine-paid external bonus payout.
(10) Attendant-paid external bonus payout.
(11) Attendant-paid progressive payout.
(12) Machine-paid progressive payout.

d. Error conditions. Each slot machine shall display and report error conditions to the online monitoring system. For machines that display only a code, definitions for all codes must be permanently affixed to the interior of the slot machine. Error conditions that must be displayed and reported include but are not limited to:

(1) Currency in.
(2) Currency out.
(3) Door open.
(4) RAM.
(5) Low battery.
(6) Program authentication.
(7) Reel spin.
(8) Power reset.

11.10(3) *Previous slot machine models.* Subject to administrator approval of specific gaming devices, slot machines may be used that do not meet the requirements of subrules 11.10(1) and 11.10(2) but have been certified under previously approved specifications by a commission-designated independent testing facility and maintain a current certification.
[**ARC 8029B**, IAB 8/12/09, effective 9/16/09]

491—11.11(99F) Slot machine specifications. Rescinded IAB 8/12/09, effective 9/16/09.

491—11.12(99F) Progressive slot machines.

11.12(1) *Meter required.* A progressive machine is a slot machine game with an award amount that increases based on a function of credits bet on the slot machine and that is awarded when a particular configuration of symbols or events is displayed on the slot machine. Random events generating awards independent of the base slot machine game and not dependent on any specific slot machine game shall be considered bonus features. A progressive slot machine or group of linked progressive slot machines must have a meter showing the progressive jackpot payout.

11.12(2) *Progressive controllers.* The reset or base value and the rate of increment of a progressive jackpot game must be filed with a commission representative prior to implementation. A reset or base value must equal or exceed the equivalent nonprogressive jackpot payout.

11.12(3) *Limits.* A facility may impose a limit on the progressive jackpot payout of a slot machine if the limit imposed is greater than the progressive jackpot payout at the time the limit is imposed. The facility must prominently display a notice informing the public of the limit. No progressive meter may be turned back to a lesser amount unless one of the following circumstances occurs:

a. The amount shown on the progressive meter is paid to a player as a jackpot.

b. It is necessary to adjust the progressive meter to prevent it from displaying an amount greater than the limit imposed by the facility.

c. It is necessary to change the progressive indicator because of game malfunction.

11.12(4) *Transfer of jackpots.* In the event of malfunction, replacement, or other reason approved by the commission, a progressive jackpot that is removed shall be transferred, less the reset value, to other progressive slot machine jackpots of similar progressive wager and probability at the same facility within 30 days from the removal date. In the event a similar progressive jackpot at the same facility is unavailable, other transfers shall be allowed. A commission representative shall be notified in writing prior to a removal or transfer.

11.12(5) *Records required.* Records must be maintained that record the amount shown on a progressive jackpot meter. Supporting documents must be maintained to explain any reduction in the payoff amount from a previous entry. The records and documents must be retained for a period of three years unless permission to destroy them earlier is given in writing by the administrator.

11.12(6) *Transfer of progressive slot machines.* A progressive slot machine, upon permission of the administrator, may be moved to a different facility if a bankruptcy, loss of license, or other good cause warrants.

11.12(7) *Linked machines.* Each machine on the link shall have the same probability of winning the progressive jackpot, adjusted for the total amount wagered. The product of the odds of winning the progressive jackpot multiplied by the maximum amount wagered shall be equal for all games on the link.

11.12(8) *Wide area progressive systems.* A wide area progressive system is a method of linking progressive slot machines or electronic gaming machines across telecommunication lines as part of a network connecting participating facilities. The purpose of a wide area progressive system is to offer a common progressive jackpot (system jackpot) at all participating locations. The operation of a wide area progressive system (multilink) is permitted subject to the following conditions:

a. The method of communication over the multilink must consist of dedicated on-line communication lines (direct connect) or equivalent as determined by the administrator, dial-tone lines, or wireless communication which may be subject to certain restrictions imposed by the administrator.

b. All communication between each facility location and the central system site must be encrypted.

c. All meter reading data must be obtained in real time in an on-line automated fashion. When requested to do so, the system must return meter readings on all slot machines or electronic gaming machines attached to the multilink within a reasonable time of the meter acquisition request. Manual reading of meter values may not be substituted for these requirements. There is no restriction as to the acceptable method of obtaining meter reading values, provided that the methods consist of either pulses from any machine computer board or associated wiring, or the use of serial interface to the machine's random access memory (RAM) or other nonvolatile memory.

d. The multilink must have the ability to monitor entry into the front door of the machine as well as the logic area of the machine and report such data to a central system.

e. The central system site must be located in the state of Iowa, be equipped with a noninterruptible power supply, and the central computer must be capable of on-line data redundancy should hard disk peripherals fail during operation. The office containing the central computer shall be equipped with a surveillance system that has been approved by the administrator. Any person authorized to provide a multilink shall be required to keep and maintain an entry and exit log for the office containing the central computer. Any person authorized to provide a multilink shall provide access to the office containing the central computer to the administrator and shall make available to the administrator all books, records, and information required by the administrator in fulfilling its regulatory purpose.

f. Any person authorized to provide a multilink must suspend play on the multilink if a communication failure of the system cannot be corrected within 24 consecutive hours.

g. Approval by a commission representative of any multilink shall occur only after the administrator has reviewed the multilink software and hardware and is satisfied that the operation of the system meets accepted industry standards for multilink products, as well as any other requirements that the administrator may impose to ensure the integrity, security, and legal operation of the multilink.

h. A meter that shows the amount of the system jackpot must be conspicuously displayed at or near the machines to which the jackpot applies. The system jackpot meter need not precisely show the actual moneys in the system jackpot award at each instant. Nothing shall prohibit the use of odometer or other paced updating progressive displays. In the case of the use of paced updating displays, the system jackpot meter must display the winning value after the jackpot broadcast is received from the central system, providing the remote site is communicating to the central computer. If a system jackpot is recognized in the middle of a systemwide poll cycle, the system jackpot display may contain a value less than the aggregated amount calculated by the central system. The coin values from the remaining portion of the poll cycle will be received by the central system but not the local site, in which case the system jackpot amount paid will always be the higher of the two reporting amounts.

i. When a system jackpot is won, a person authorized to provide the multilink shall have the opportunity to inspect the machine, storage media, the error events received by the central system, and any other data which could reasonably be used to ascertain the validity of the jackpot.

(1) The central system shall produce reports that will clearly demonstrate the method of arriving at the payoff amount. This shall include the coins contributed beginning with the polling cycle immediately following the previous jackpot and will include all coins contributed up to, and including, the polling cycle, which includes the jackpot signal. Coins contributed to and registered by the system before the jackpot message is received will be deemed to have been contributed to the progressive amount prior to the current jackpot. Coins contributed to the system subsequent to the jackpot message's being received as well as coins contributed to the system before the jackpot message is received by the system, but registered after the jackpot message is received at the system, will be deemed to have been contributed to the progressive amount of the next jackpot.

(2) The system jackpot may be disbursed in periodic payments as long as each machine clearly displays the fact that the jackpot will be paid in such periodic payments. In addition, the number of periodic payments and time between payments must be clearly displayed on the face of the slot machine in a nonmisleading manner.

(3) Two system jackpots which occur in the same polling cycle before the progressive amount can reset will be deemed to have occurred simultaneously; therefore, each winner shall receive the full amount shown on the system jackpot meter.

j. Any person authorized to provide a multilink must supply to the commission, as requested, reports which support and verify the economic activity of the system.

(1) Any person authorized to provide a multilink must supply to the commission, as requested, reports and information indicating the amount of, and basis for, the current system jackpot. Such reports may include an aggregate report and a detail report. The aggregate report may show only the balancing of the system with regard to systemwide totals. The detail report shall be in such form as to indicate for each machine, summarized by location, the coin-in totals as such terms are commonly understood in the industry.

(2) In addition, upon the invoicing of any facility participating in a multilink, each such facility must be given a printout of each machine operated by that facility, the coins contributed by each machine to the system jackpot for the period for which an invoice is remitted, and any other information required by the commission to confirm the validity of the facility's contributions to the system jackpot.

k. In calculating adjusted gross receipts, a facility may deduct its pro-rata share of the present value of any system jackpots awarded. Such deduction shall be listed on the detailed accounting records provided by the person authorized to provide the multilink. A facility's pro-rata share is based on the number of coins in from that facility's machines on the multilink, compared to the total amount of coins in on the whole system for the time period(s) between jackpot(s) awarded.

l. In the event a facility ceases operations and a progressive jackpot is awarded subsequent to the last day of the final month of operation, the facility may not file an amended wagering tax submission or make a claim for a wagering tax refund based on its contributions to that particular progressive prize pool.

m. A facility, or an entity that is licensed as a manufacturer or distributor, shall provide the multilink, in accordance with a written agreement which shall be reviewed and approved by the commission prior to offering the jackpots.

n. The payment of any system jackpot offered on a multilink shall be administered by the person authorized to provide the multilink, and such person shall have primary liability for payment of any system jackpot the person administers. In addition, any facility shall have secondary liability for the payment of system jackpots won on a multilink in which the licensee is or was a participant if and to the extent that the person authorized to provide the multilink fails to make payment when due.

o. A person who is authorized to provide the multilink shall comply with the following:

(1) A reserve shall be established and maintained by the provider of the multilink in an amount of not less than the sum of the following amounts:

1. The present value of the aggregate remaining balances owed on all jackpots previously won by patrons on the multilink.

2. The present value of the amount currently reflected on the jackpot meters of the multilink.

3. The present value of one additional reset (start amount) of the multilink.

(2) The reserve shall continue to be maintained until all payments owed to winners of the system jackpots have been made.

(3) For system jackpots disbursed in periodic payments, any qualified investment shall be purchased within 90 days following notice of the win of the system jackpot, and a copy of such qualified investment will be provided to the commission office within 30 days of purchase. Any qualified investment shall have a surrender value at maturity, excluding any interest paid before the maturity date, equal to or greater than the value of the corresponding periodic jackpot payment, and shall have a maturity date prior to the date the periodic jackpot payment is required to be made.

(4) The person authorized to provide the multilink shall not be permitted to sell, trade, or otherwise dispose of any qualified investments prior to their maturity unless approval to do so is first obtained from the commission.

(5) Upon becoming aware of an event of noncompliance with the terms of the reserve requirement mandated by subparagraph (1) above, the person authorized to provide the multilink must immediately notify the commission of such event. An event of noncompliance includes a nonpayment of a jackpot periodic payment or a circumstance which may cause the person authorized to provide the multilink to be unable to fulfill, or which may otherwise impair the person's ability to satisfy, the person's jackpot payment obligations.

(6) On a quarterly basis, the person authorized to provide the multilink must deliver to the commission office a calculation of system reserves required under subparagraph (1) above. The calculation shall come with a certification of financial compliance signed by a duly authorized financial officer of the person authorized to provide the multilink, on a form prescribed by the commission, validating the calculation.

(7) The reserve required under subparagraph (1) must be examined by an independent certified public accountant according to procedures approved by the commission. Two copies of the report must be submitted to the commission office within 90 days after the conclusion of the fiscal year of the person authorized to provide the multilink.

p. For system jackpots disbursed in periodic payments, subsequent to the date of the win, a winner may be offered the option to receive, in lieu of periodic payments, a discounted single cash payment in the form of a "qualified prize option," as that term is defined in Section 451(h) of the Internal Revenue Code. The person authorized to provide the multilink shall calculate the single cash payment based on the discount rate. Until the new discount rate becomes effective, the discount rate selected by the person authorized to provide the multilink shall be used to calculate the single cash payment for all qualified prizes that occur subsequent to the date of the selected discount rate.

[**ARC 7757B**, IAB 5/6/09, effective 6/10/09; **ARC 8029B**, IAB 8/12/09, effective 9/16/09; **ARC 9018B**, IAB 8/25/10, effective 9/29/10]

491—11.13(99F) Licensing of manufacturers and distributors of gambling games or implements of gambling.

11.13(1) *Impact on gambling.* In considering whether a manufacturer or distributor applicant will be licensed or a specific product will be distributed, the administrator shall give due consideration to the economic impact of the applicant's product, the willingness of a licensed facility to offer the product to the public, and whether its revenue potential warrants the investigative time and effort required to maintain effective control over the product.

11.13(2) *Licensing standards.* Standards which shall be considered when determining the qualifications of an applicant shall include, but are not limited to, financial stability; business ability and experience; good character and reputation of the applicant as well as all directors, officers, partners, and employees; integrity of financial backers; and any effect on the Iowa economy.

11.13(3) *Application procedure.* Application for a manufacturer's or a distributor's license shall be made to the commission for approval by the administrator. In addition to the application, the following must be completed and presented when the application is filed:

a. Disclosure of ownership interest, directors, or officers of licensees.

(1) An applicant or licensee shall notify the administrator of the identity of each director, corporate officer, owner, partner, joint venture participant, trustee, or any other person who has any beneficial interest of 5 percent or more, direct or indirect, in the business entity. For any of the above, as required by the administrator, the applicant or licensee shall submit background information on forms supplied by the division of criminal investigation and any other information the administrator may require.

For purposes of this rule, beneficial interest includes all direct and indirect forms of ownership or control, voting power, or investment power held through any contract, lien, lease, partnership, stockholding, syndication, joint venture, understanding, relationship (including family relationship), present or reversionary right, title or interest, or otherwise.

(2) For ownership interests of less than 5 percent, the administrator may request a list of these interests. The list shall include names, percentages owned, addresses, social security numbers, and dates of birth. The administrator may request the same information required of those individuals in subparagraph (1) above.

b. Investigative fees.

(1) Advance payment. The department of public safety may request payment of the investigative fee in advance as a condition to beginning investigation.

(2) Payment required. The administrator may withhold final action with respect to any application until all investigative fees have been paid in full.

c. A bank or cashier's check made payable to the Iowa Racing and Gaming Commission for the annual license fee as follows:

(1) A manufacturer's license shall be $250.

(2) A distributor's license shall be $1,000.

d. A copy of each of the following:

(1) Articles of incorporation and certificate of incorporation, if the business entity is a corporation.

(2) Partnership agreement, if the business entity is a partnership.

(3) Trust agreement, if the business entity is a trust.

(4) Joint venture agreement, if the business entity is a joint venture.

(5) List of employees of the aforementioned who may have contact with persons within the state of Iowa.

e. A copy of each of the following types of proposed distribution agreements, where applicable:

(1) Purchase agreement(s).

(2) Lease agreement(s).

(3) Bill(s) of sale.

(4) Participation agreement(s).

f. Supplementary information. Each applicant shall promptly furnish the administrator with all additional information pertaining to the application or the applicant which the administrator may require.

Failure to supply the information requested within five days after the request has been received by the applicant shall constitute grounds for delaying consideration of the application.

g. Any and all changes in the applicant's legal structure, directors, officers, or the respective ownership interests must be promptly filed with the administrator.

h. The administrator may deny, suspend, or revoke the license of an applicant or licensee in which a director, corporate officer, or holder of a beneficial interest includes or involves any person or entity which would be, or is, ineligible in any respect, such as through want of character, moral fitness, financial responsibility, professional qualifications, or due to failure to meet other criteria employed by the administrator, to participate in gaming regardless of the percentage of ownership interest involved. The administrator may order the ineligible person or entity to terminate all relationships with the licensee or applicant, including divestiture of any ownership interest or beneficial interest at acquisition cost.

i. Disclosure. Disclosure of the full nature and extent of all beneficial interests may be requested by the administrator and shall include the names of individuals and entities, the nature of their relationships, and the exact nature of their beneficial interest.

j. Public disclosure. Disclosure is made for the benefit of the public, and all documents pertaining to the ownership filed with the administrator shall be available for public inspection.

11.13(4) *Temporary license certificates.*

a. A temporary license certificate may be issued at the discretion of the administrator.

b. Temporary licenses—period valid. Any certificate issued at the discretion of the administrator shall be valid for a maximum of 120 calendar days from the date of issue.

Failure to obtain a permanent license within the designated time may result in revocation of the license eligibility, fine, or suspension.

11.13(5) *Withdrawal of application.* A written notice of withdrawal of application may be filed by an applicant at any time prior to final action. No application shall be permitted to be withdrawn unless the administrator determines the withdrawal to be in the public interest. No fee or other payment relating to any application shall become refundable by reason of withdrawal of the application.

11.13(6) *Record keeping.*

a. Record storage required. Distributors and manufacturers shall maintain adequate records of business operations, which shall be made available to the administrator upon request. These records shall include:

(1) All correspondence with the administrator and other governmental agencies on the local, state, and federal level.

(2) All correspondence between the licensee and any of its customers who are applicants or licensees under Iowa Code chapter 99F.

(3) A personnel file on each employee of the licensee, including sales representatives.

(4) Financial records of all transactions with facilities and all other licensees under these regulations.

b. Record retention. The records listed in 11.13(6)*"a"* shall be retained as required by 491—subrule 5.4(14).

11.13(7) *Violation of laws or regulations.* Violation of any provision of any laws of the state or of the United States of America or of any rules of the commission may constitute an unsuitable method of operation, subjecting the licensee to limiting, conditioning, restricting, revoking or suspending the license, or fining the licensee, or any combination of the above.

11.13(8) *Consent to inspections, searches, and seizures.* Each manufacturer or distributor licensed under this chapter shall consent to inspections, searches, and seizures deemed necessary by the administrator and authorized by law in order to enforce licensing requirements.

These rules are intended to implement Iowa Code chapter 99F.

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CHAPTER 43
PRACTICE OF CHIROPRACTIC PHYSICIANS

[Prior to 7/24/02, see 645—40.1(151) and 645—40.17(151) to 645—40.24(147,272C)]

645—43.1(151) Definitions. The following definitions shall be applicable to the rules of the Iowa board of chiropractic.

"Active chiropractic physiotherapy" means therapeutic treatment performed by the patient with the assistance and guidance of the chiropractic assistant including, but not limited to, exercises and functional activities that promote strength, endurance, flexibility, and coordination.

"Acupuncture," pursuant to Iowa Code section 148E.1, means a form of health care developed from traditional and modern oriental medical concepts that employs oriental medical diagnosis and treatment, and adjunctive therapies and diagnostic techniques, for the promotion, maintenance, and restoration of health and the prevention of disease.

"Adjustment/manipulation of neuromusculoskeletal structures" means the use by a doctor of chiropractic of a skillful treatment based upon differential diagnosis of neuromusculoskeletal structures and procedures related thereto by the use of passive movements with the chiropractic physician's hands or instruments in a manipulation of a joint by thrust so the patient's volitional resistance cannot prevent the motion. The manipulation is directed toward the goal of restoring joints to their proper physiological relationship of motion and related function. Movement of the joint is by force beyond its active limit of motion, but within physiologic integrity. Adjustment or manipulation commences where mobilization ends and specifically begins when the elastic barrier of resistance is encountered by the doctor of chiropractic and ends at the limit of anatomical integrity. Adjustment or manipulation as described in this definition is directed to the goal of the restoration of joints to their proper physiological relationship of motion and related function, release of adhesions or stimulation of joint receptors. Adjustment or manipulation as described in this definition is by hand or instrument. The primary emphasis of this adjustment or manipulation is upon specific joint element adjustment or manipulation and treatment of the articulation and adjacent tissues of the neuromusculoskeletal structures of the body and nervous system, using one or more of the following:

1. Impulse adjusting or the use of sudden, high velocity, short amplitude thrust of a nature that patient volitional resistance is overcome, commencing where the motion encounters the elastic barrier of resistance and ending at the limit of anatomical integrity.
2. Instrument adjusting, utilizing instruments specifically designed to deliver sudden, high velocity, short amplitude thrust.
3. Light force adjusting, utilizing sustained joint traction or applied directional pressure, or both, which may be combined with passive motion to restore joint mobility.
4. Long distance lever adjusting, utilizing forces delivered at some distance from the dysfunctional site and aimed at transmission through connected structures to accomplish joint mobility.

"Anatomic barrier" means the limit of motion imposed by anatomic structure, the limit of passive motion.

"Chiropractic assistant" means a person who has satisfactorily completed a chiropractic assistant training program to perform selected chiropractic health care services under the supervision of a chiropractic physician.

"Chiropractic insurance consultant" means an Iowa-licensed chiropractic physician registered with the board who serves as a liaison and advisor to an insurance company.

"Chiropractic manipulation" means care of an articular dysfunction or neuromusculoskeletal disorder by manual or mechanical adjustment of any skeletal articulation and contiguous articulations.

"Differential diagnosis" means to examine the body systems and structures of a human subject to determine the source, nature, kind or extent of a disease, vertebral subluxation, neuromusculoskeletal disorder or other physical condition, and to make a determination of the source, nature, kind, or extent of a disease or other physical condition.

"Elastic barrier" means the range between the physiologic and anatomic barrier of motion in which passive ligamentous stretching occurs before tissue disruption.

"Extremity manipulation" means a corrective thrust or maneuver by a doctor of chiropractic by hand or instrument based upon differential diagnosis of neuromusculoskeletal structures applied to a joint of the appendicular skeleton.

"Malpractice" means any error or omission, unreasonable lack of skill, or failure to maintain a reasonable standard of care by a chiropractic physician in the practice of the profession.

"Mobilization" means movement applied singularly or repetitively within or at the physiological range of joint motion, without imparting a thrust or impulse, with the goal of restoring joint mobility.

"Passive chiropractic physiotherapy" means therapeutic treatment administered by the chiropractic assistant and received by the patient including, but not limited to, mechanical, electrical, thermal, or manual methods.

"Physiologic barrier" means the limit of active motion, which can be altered to increase range of active motion by warm-up activity.

"Practice of acupuncture," pursuant to Iowa Code section 148E.1, means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based upon oriental medical diagnosis as a primary mode of therapy. Adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, and the recommendation of dietary guidelines and therapeutic exercise based on traditional oriental medicine concepts.

"Supervising chiropractic physician" means the Iowa-licensed chiropractor responsible for supervision of services provided to a patient by a chiropractic assistant.

"Supervision" means the physical presence and direction of the supervising chiropractic physician at the location where services are rendered.

645—43.2(147,272C) Principles of chiropractic ethics. The following principles of chiropractic ethics are hereby adopted by the board relative to the practice of chiropractic in this state.

43.2(1) These principles are intended to aid chiropractic physicians individually and collectively in maintaining a high level of ethical conduct. These are standards by which a chiropractic physician may determine the propriety of the chiropractic physician's conduct in the chiropractic physician's relationship with patients, with colleagues, with members of allied professions, and with the public.

43.2(2) The principal objective of the chiropractic profession is to render service to humanity with full respect for the dignity of the person. Chiropractic physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

43.2(3) Chiropractic physicians should strive continually to improve chiropractic knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

43.2(4) A chiropractic physician should practice a method of healing founded on a scientific basis, and should not voluntarily associate professionally with anyone who violates this principle.

43.2(5) The chiropractic profession should safeguard the public and itself against chiropractic physicians deficient in moral character or professional competence. Chiropractic physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

43.2(6) A chiropractic physician may choose whom to serve. In an emergency, however, services should be rendered to the best of the chiropractic physician's ability. Having undertaken the case of a patient, the chiropractic physician may not neglect the patient; and, unless the patient has been discharged, the chiropractic physician may discontinue services only after giving adequate notice.

43.2(7) A chiropractic physician should not dispose of services under terms or conditions which tend to interfere with or impair the free and complete exercise of professional judgment and skill or tend to cause a deterioration of the quality of chiropractic care.

43.2(8) A chiropractic physician should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of chiropractic service may be enhanced thereby.

43.2(9) A chiropractic physician may not reveal the confidences entrusted in the course of chiropractic attendance, or the deficiencies observed in the character of patients, unless required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

43.2(10) The honored ideals of the chiropractic profession imply that the responsibilities of the chiropractic physician extend not only to the individual, but also to society where these responsibilities deserve interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

645—43.3(514F) Utilization and cost control review.

43.3(1) The board shall establish utilization and cost control review (UCCR) committee(s). A UCCR committee shall be established by approval of the board upon a showing that the committee meets the requirements of this rule. The name of each committee and a list of committee members shall be on file with the board and available to the public. As a condition of board approval, each committee shall agree to submit to the board an annual report which meets the requirements of this rule.

43.3(2) Each member of a UCCR committee shall:

a. Hold a current license in Iowa.

b. Have practiced chiropractic in the state of Iowa for a minimum of five years prior to appointment.

c. Be actively involved in a chiropractic practice during the term of appointment as a UCCR committee member.

d. Have no pending disciplinary action, no disciplinary action taken during the three years prior to appointment, and no disciplinary action pending or taken during the period of appointment.

e. Have no malpractice judgment awarded or settlement paid during the three years prior to appointment or during the period of appointment.

f. Not assist in the review or adjudication of claims in which the committee member may reasonably be presumed to have a conflict of interest.

g. Rescinded IAB 5/10/06, effective 6/14/06.

43.3(3) Procedures for utilization and cost control review. A request for review may be made to the UCCR committee by any person governed by the various chapters of Title XIII, subtitle 1, of the Iowa Code, self-insurers for health care benefits to employees, other third-party payers, chiropractic patients or licensees.

a. There shall be a reasonable fee, as established by the UCCR committee and approved by the board, for services rendered, which will be made payable directly to the UCCR committee that conducts the review. Each UCCR committee approved by the board shall make a yearly accounting to the board.

b. A request for service shall be submitted to the executive director of the UCCR committee on a submission form approved by the board, and shall be accompanied by the number of copies required by the UCCR committee.

c. The UCCR committee shall respond in writing to the parties involved with its findings and recommendations within 90 days of the date the request for review was submitted. The committee shall review the appropriateness of levels of treatment and give an opinion as to the reasonableness of charges for diagnostic or treatment services rendered as requested.

43.3(4) Types of cases reviewed shall include:

a. Utilization.

(1) Frequency of treatment;

(2) Amount of treatment;

(3) Necessity of service;

(4) Appropriateness of treatment.

b. Usual and customary service.

43.3(5) Criteria for review may include but are not limited to:

a. Was diagnosis compatible and consistent with information?

b. Were X-ray and other examination procedures adequate, or were they insufficient or unrelated to history or diagnosis?

c. Were clinical records adequate, complete, and of sufficient frequency?

d. Was treatment consistent with diagnosis?

e. Was treatment program consistent with scientific knowledge and with academic and clinical training provided in accredited chiropractic colleges?

f. Were charges reasonable and customary for the service?

43.3(6) Confidentiality. Members of the UCCR committee shall observe the requirements of confidentiality imposed by Iowa Code chapter 272C.

43.3(7) Annual report. Each UCCR committee shall annually submit a report to the board, and shall meet to review that report with the board chairperson or designee upon the board's request. The annual report shall include the following information:

a. The fee to be charged the party requesting UCCR review.

b. A report regarding the activities of the committee for the past year, including a report regarding each review conducted, the conclusions reached regarding that review, and any recommendations made following the review.

43.3(8) A conclusion or recommendation, or both, made by a UCCR committee does not constitute a decision of the board.

645—43.4(151) Chiropractic insurance consultant.

43.4(1) A chiropractic insurance consultant advises insurance companies, third-party administrators and other similar entities of Iowa standards of (a) recognized and accepted chiropractic services and procedures permitted by the Iowa Code and administrative rules and (b) the propriety of chiropractic diagnosis and care.

43.4(2) All licensees who review chiropractic records for the purposes of determining the adequacy or sufficiency of chiropractic treatments, or the clinical indication for those treatments, shall notify the board annually that they are engaged in those activities and of the location where those activities are performed.

43.4(3) Licensed chiropractic physicians shall not hold themselves out as chiropractic insurance consultants unless they meet the following requirements:

a. Hold a current license in Iowa.

b. Have practiced chiropractic in the state of Iowa during the immediately preceding five years.

c. Are actively involved in a chiropractic practice during the term of appointment as a chiropractic insurance consultant. Active practice includes but is not limited to maintaining an office location and providing clinical care to patients.

645—43.5(151) Acupuncture. A chiropractic physician who engages in the practice of acupuncture shall maintain documentation that shows the chiropractic physician has successfully completed a course in acupuncture consisting of at least 100 hours of traditional, in-person classroom instruction with the instructor on site. The licensee shall maintain a transcript or certification of completion showing the licensee's name, school or course sponsor's name, date of course completion or graduation, grade or other evidence of successful completion, and number of course hours. The licensee shall provide the transcript or certification of completion to the board upon request.

[**ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—43.6(151) Nonprofit nutritional product sales. Rescinded IAB 11/26/03, effective 12/31/03.

645—43.7(151) Adjunctive procedures.

43.7(1) Adjunctive procedures are defined as procedures related to differential diagnosis.

43.7(2) For any applicant for licensure to practice chiropractic in the state of Iowa who chooses to be tested in limited adjunctive procedures, those limited procedures must be adequate for the applicant to come to a differential diagnosis in order to pass the examination.

43.7(3) Applicants for licenses to practice chiropractic who refuse to utilize any of the adjunctive procedures which they have been taught in approved colleges of chiropractic must adequately show the board that they can come to an adequate differential diagnosis without the use of adjunctive procedures.

645—43.8(151) Physical examination. The chiropractic physician is to perform physical examinations to determine human ailments, or the absence thereof, utilizing principles taught by chiropractic colleges. Physical examination procedures shall not include prescription drugs or operative surgery.

645—43.9(151) Gonad shielding. Gonad shielding of not less than 0.25 millimeter lead equivalent shall be used for chiropractic patients who have not passed the reproductive age during radiographic procedures in which the gonads are in the useful beam, except for cases in which this would interfere with the diagnostic procedures.

645—43.10(151) Record keeping.

43.10(1) Chiropractic physicians shall maintain clinical records in a manner consistent with the protection of the welfare of the patient. Records shall be timely, dated, chronological, accurate, signed or initialed, legible, and easily understandable. Record-keeping rules apply to all patient records whether handwritten, typed or maintained electronically. Electronic signatures are acceptable when the record has been reviewed by the physician whose signature appears on the record.

43.10(2) Chiropractic physicians shall maintain clinical records for each patient. The clinical records shall, at a minimum, include all of the following:

a. Personal data.

(1) Name;

(2) Date of birth;

(3) Address; and

(4) Name of parent or guardian if a patient is a minor.

b. Health history. Records shall include information from the patient or the patient's parent or guardian regarding the patient's health history.

c. Patient's reason for visit. When a patient presents with a chief complaint, clinical records shall include the patient's stated health concerns.

d. Clinical examination progress notes. Records shall include chronological dates and descriptions of the following:

(1) Clinical examination findings, tests conducted, a summary of all pertinent diagnoses, and updated health assessments;

(2) Plan of intended treatment, including description of treatment, frequency and duration;

(3) Services rendered and any treatment complications;

(4) All testing ordered or performed;

(5) Diagnostic imaging report if imaging procedure is ordered or performed;

(6) Sufficient data to support the recommended treatment plan.

e. Clinical record. Each page of the clinical record shall include the patient's name, the date information was recorded and the doctor's name or facility's name.

43.10(3) Retention of records. A chiropractic physician shall maintain a patient's record(s) for a minimum of six years after the date of last examination or treatment. Records for minors shall be maintained for one year after the patient reaches the age of majority (18) or six years after the date of last examination or treatment, whichever is longer. Proper safeguards shall be maintained to ensure the safety of records from destructive elements. This provision includes both clinical and fiscal records.

43.10(4) Electronic record keeping. When electronic records are utilized, a chiropractic physician shall maintain either a duplicate hard-copy record or a backup electronic record.

43.10(5) Correction of written records. Notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line. Entries recorded at a time other than the date of the patient encounter must include the date of the entry and the initials of the author.

43.10(6) Correction of electronic records. Any alterations made after the date of service shall be visibly recorded. All alterations shall include a notation setting forth the date of alteration and identification of the author. Entries recorded at a time other than the date of the patient encounter must include the date of the entry and the initials of the author.

43.10(7) Abbreviations shall be standard and common to all health care disciplines. Nonstandard abbreviations shall be referenced with a key that is included in the record when the record is requested.

43.10(8) Confidentiality and transfer of records. Chiropractic physicians shall preserve the confidentiality of patient records. Upon signed request of the patient, the chiropractic physician shall furnish such records or copies of the records as directed by the patient within 30 days. A notation indicating the items transferred, date and method of transfer shall be maintained in the patient record. The chiropractic physician may charge a reasonable fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees. In certain instances a summary of the record may be more beneficial for the future treatment of the patient; however, if a third party requests copies of the original documentation, that request must be honored.

43.10(9) Retirement or discontinuance of practice. A licensee, upon retirement, discontinuation of the practice of chiropractic, leaving a practice, or moving from a community, shall:

a. Notify all active patients, in writing and by publication, once a week for three consecutive weeks in a newspaper of general circulation in the community. The notification shall include the following information:

(1) That the licensee intends to discontinue the practice of chiropractic in the community and that patients are encouraged to seek the services of another licensee; and

(2) How patients can obtain their records, including the name and contact information of the records custodian.

b. Make reasonable arrangements with active patients for the transfer of patient records, or copies of those records, to the succeeding licensee.

c. For the purposes of this subrule, "active patient" means a person whom the licensee has examined, treated, cared for, or otherwise consulted with during the one-year period prior to retirement, discontinuation of the practice of chiropractic, leaving a practice, or moving from a community.

43.10(10) Record-keeping procedures and standards shall be utilized for all individuals who receive treatment from a chiropractic physician in all sites where care is provided.

43.10(11) A chiropractic physician who offers a prepayment plan for chiropractic services shall:

a. Have a written prepayment policy statement that is maintained in the office and available to patients upon request. The policy statement, at a minimum, shall include provisions that:

(1) Prepaid funds will not be expended until services are provided; and

(2) The patient shall receive a prompt refund of any unused funds upon request. The refund shall be calculated based on a defined method, which shall be clearly set forth in the written prepayment policy statement.

b. Require the patient to sign and date a prepayment document that incorporates the conditions and descriptions of the written prepayment policy statement.

c. Maintain the signed and dated written prepayment policy statement in the patient's record.

[**ARC 9109B**, IAB 10/6/10, effective 11/10/10]

645—43.11(151) Billing procedures.

43.11(1) Chiropractic physicians shall maintain accurate billing records for each patient. Records may be stored on paper or electronically. The records shall contain all of the following:

a. Name, date of birth and address.

b. Diagnosis indicated with description or ICD code.

c. Services provided with description or CPT code.

d. Dates of services provided.

e. Charges for each service provided.

f. Payments made for each service and indication of the party providing payment.

g. Dates payments are made.

h. Balance due for any outstanding charges.

43.11(2) Chiropractic physicians shall preserve the confidentiality of billing records.

43.11(3) Upon signed request of the patient, the chiropractic physician shall furnish billing records or copies of the records as directed by the patient within 30 days. The chiropractic physician may charge a reasonable fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees.

43.11(4) Each chiropractic physician is responsible for the accuracy and validity of billings submitted under the chiropractic physician's name.

43.11(5) Chiropractic physicians:

a. Who are owners, operators, members, partners, shareholders, officers, directors, or managers of a chiropractic clinic will be responsible for the policies, procedures and billings generated by the clinic.

b. Who provide clinical services are required to familiarize themselves with the clinic's billing practices to ensure that the services rendered are accurately reflected in the billings generated. In the event an error occurs which results in an overbilling, the licensee must promptly make reimbursement of the overbilling whether or not the licensee is in any way compensated for such reimbursement by an employer, agent or any other individual or business entity responsible for such error.

43.11(6) A chiropractic physician has a right to review and correct all billings submitted under the chiropractic physician's name or identifying number(s). Signature stamps or electronically generated signatures shall be utilized only with the authorization of the chiropractic physician whose name or signature is designated. Such authorization may be revoked at any time in writing by the chiropractic physician.

43.11(7) Chiropractic physicians shall not knowingly:

a. Increase charges when a patient utilizes a third-party payment program.

b. Report incorrect dates or types of service on any billing documents.

c. Submit charges for services not rendered.

d. Submit charges for services rendered which are not documented in a patient's record.

e. Bill patients or make claims under a third-party payer contract for chiropractic services that have not been performed.

f. Bill patients or make claims under a third-party payer contract in a manner which misrepresents the nature of the chiropractic services that have been performed.

43.11(8) For cases not involving third-party payers, nothing in this rule shall prevent a chiropractic physician from providing a fee reduction for reasonable time of service or substantiated hardship cases. The chiropractic physician shall document time of service or hardship case fee reduction provisions in the patient record.

43.11(9) The chiropractic physician shall not enter into an agreement to waive, abrogate, or rebate the deductible or copayment amounts of any third-party payer contract by forgiving any or all of any patient's obligation for payment thereunder, except in substantiated hardship cases, unless the third-party payer is notified in writing of the fact of such waiver, abrogation, rebate, or forgiveness in accordance with the third-party payer contract. The chiropractic physician shall document any hardship case fee reduction provisions in the patient record.

645—43.12(151) Chiropractic assistants. The requirements of this rule shall become effective on July 1, 2009.

43.12(1) *Supervisory responsibilities of the chiropractic physician.*

a. The supervising chiropractic physician shall ensure at all times that the chiropractic assistant has the necessary training and skills as required by these rules to competently perform the delegated services.

b. The supervising chiropractic physician may delegate services to a chiropractic assistant that are within the scope of practice of the chiropractic physician in a manner consistent with these rules. Violation of these rules shall be grounds for discipline under 645—Chapter 45.

c. A chiropractic physician shall not delegate to the chiropractic assistant the following:

(1) Services outside the chiropractic physician's scope of practice;

(2) Initiation, alteration, or termination of chiropractic treatment programs;

(3) Chiropractic manipulation and adjustments;

(4) Diagnosis of a condition.

d. A supervising chiropractic physician shall ensure that a chiropractic assistant is informed of the supervisor and chiropractic assistant relationship and is responsible for all services performed by the chiropractic assistant.

43.12(2) *Education requirements for chiropractic assistants.*

a. The supervising chiropractic physician shall ensure that a chiropractic assistant has completed a chiropractic assistant training program. A chiropractic assistant training program shall include training and instruction on the use of chiropractic physiotherapy procedures related to services to be provided by the chiropractic assistant. Any chiropractic assistant training program shall be provided by an approved CCE-accredited chiropractic college or a chiropractic state association.

b. Chiropractic assistants performing active chiropractic physiotherapy procedures are required to complete 12 hours of instruction, of which 6 hours shall be clinical experience under the supervision of the chiropractic physician.

c. Chiropractic assistants performing passive chiropractic physiotherapy procedures are required to complete 12 hours of instruction, of which 6 hours shall be clinical experience under the supervision of the chiropractic physician.

d. If both paragraphs *"b"* and *"c"* apply, then 12 hours of instruction for active chiropractic physiotherapy procedures and 12 hours of instruction for passive chiropractic physiotherapy procedures shall be required for a total of 24 hours of instruction.

e. The supervising chiropractic physician shall provide a written attestation to the chiropractic college that the chiropractic assistant has completed the clinical experience. The college shall issue a separate certificate of completion for the active or passive chiropractic training program as defined in paragraphs *"b," "c"* and *"d"* of this subrule.

f. The chiropractic physician shall maintain in the chiropractic physician's primary place of business proof of the chiropractic assistant's completion of the training program. Copies of such documents shall be provided to the board upon request.

[**ARC 0006C**, IAB 2/8/12, effective 3/14/12]

These rules are intended to implement Iowa Code chapter 151.

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[Prior to 12/21/05, see rules 661—16.700(103A,104A) to 661—16.720(103A,104A)]

661—302.1(103A,104A) Purpose and scope. Rules 661—302.1(103A,104A) through 661—302.20(103A,104A) are intended to ensure that buildings and facilities used by the public, other than places of worship, are accessible to, and functional for, persons with disabilities. Rule 661—302.3(103A,104A) applies statewide to new construction of buildings and facilities available to the public and to renovation and rehabilitation projects on existing buildings and facilities when local or state building codes require compliance with standards for new construction. Rule 661—302.20(103A,104A) applies statewide to construction of multiunit residential buildings.

NOTE A: Although rule 661—302.2(103A,104A) is based upon the federal 2010 ADA Standards for Accessible Design and adopts the language of the 2010 ADA Standards for Accessible Design by reference, and rule 661—302.20(103A,104A) is based upon the requirements of the federal Fair Housing Act, state and local building officials charged with enforcement of these rules are unable to warrant the acceptance of any approval of design or construction by federal agencies or any other state. A state or local official's decision to approve a building plan under these rules does not prevent the federal government or another state from making a different decision under applicable law, notwithstanding any similarities among such laws.

NOTE B: Other federal and state laws address requirements for accessibility for persons with disabilities and may be applicable to buildings and facilities subject to rules 661—302.1(103A,104A) through 661—302.20(103A,104A). Nothing in these rules should be interpreted as limiting the applicability of other provisions of state or federal law. These provisions include, but are not limited to, the following:

1. Iowa Code chapter 216, the Iowa civil rights Act of 1965.
2. Iowa Code chapter 216C, which enumerates the rights of persons who are blind or partially blind and persons with physical disabilities.
3. Iowa Code chapter 321L and 661—Chapter 18, which relate to requirements for parking for persons with disabilities.
4. The federal Architectural Barriers Act of 1968 (Public Law 90-480).
5. The federal Rehabilitation Act of 1973 (Public Law 93-112).
6. The federal Fair Housing Act of 1968 (Public Law 90-284), the federal Fair Housing Amendments Act of 1988 (Public Law 100-430), and related regulations, including 24 CFR 100, Subpart D.

[**ARC 9993B**, IAB 2/8/12, effective 3/15/12]

661—302.2(103A,104A) Definitions. The following definitions are adopted for purposes of rules 661—302.1(103A,104A) through 661—302.20(103A,104A).

"ADA" means the federal Americans with Disabilities Act, Public Law 101-336.

"ADAAG" means Americans with Disabilities Act Accessibility Guidelines for Buildings and Facilities, 28 CFR Part 36, Appendix A, as revised through July 1, 1994.

"ADASAD 2010" means 2010 ADA Standards for Accessible Design, published by the U.S. Department of Justice, September 15, 2010. Included in the publication are accessibility standards for state and local government facilities and accessibility standards for public accommodations and commercial facilities.

NOTE: Copies of ADASAD 2010 and additional explanatory material may be downloaded from http://www.ada.gov/regs2010/ADAregs2010.htm.

"IBC 2009" means the International Building Code, 2009 edition, published by the International Code Council, 5203 Leesburg Pike, Suite 600, Falls Church, VA 22041.

[**ARC 9993B**, IAB 2/8/12, effective 3/15/12]

661—302.3(103A,104A) Accessibility of buildings and facilities available to the public. Buildings and facilities which are available to the public, other than places of worship, shall comply with one of the following:

302.3(1) Applicable provisions of ADASAD 2010, or

302.3(2) IBC 2009, Chapter 11 and applicable accessibility provisions contained in IBC 2009.

NOTE 1: Approval of construction plans based upon compliance with the applicable provisions of the International Building Code, 2009 edition, as provided, does not relieve the designer, builder, building owner, or building operator from responsibility under federal law to comply with all applicable provisions of the 2010 ADA Standards for Accessible Design.

NOTE 2: Amendments to requirements contained in the state of Iowa building code do not apply retroactively to existing construction. New amendments to the state building code apply only to construction which occurs on or after the effective date of the amendments.

[**ARC 9993B**, IAB 2/8/12, effective 3/15/12]

Rules 661—302.1(103A,104A) to 661—302.3(103A,104A) are intended to implement Iowa Code sections 103A.7, 103A.9, and 104A.1.

661—302.4(103A,104A) Site development. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.5(103A,104A) Building elements and spaces accessible to the physically handicapped. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.6(103A,104A) Restaurants and cafeterias. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.7(103A,104A) Medical care facilities. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.8(103A,104A) Business and mercantile facilities. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.9(103A,104A) Libraries. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.10(103A,104A) Transient lodging facilities. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.11(103A,104A) Transportation facilities. Rescinded IAB 2/8/12, effective 3/15/12.

661—302.12 to **302.19** Reserved.

661—302.20(103A,104A) Making apartments accessible and functional for persons with disabilities.

302.20(1) Multiple dwelling unit buildings. This rule shall apply to all multiple dwelling unit buildings that consist of four or more dwelling units, if such buildings have one or more elevators. In such buildings without an elevator, all ground floor units must be accessible. The requirements of this rule shall apply to the individual dwelling units and the common use spaces which are accessible to persons with disabilities in multiple dwelling unit buildings.

EXCEPTION 1: A multiple dwelling unit building shall be deemed to be in compliance with this rule if it is located in a local jurisdiction which has enacted accessibility rules which have been recognized by the U.S. Department of Housing and Urban Development as providing a safe harbor for compliance with the accessibility requirements established in the federal Fair Housing Act and if the building has been found to be in compliance with those requirements, unless the building is required to comply with the requirements of the Uniform Federal Accessibility Standards, or other applicable standards which may be more restrictive than the provisions of this rule.

EXCEPTION 2: Certain multiple dwelling unit buildings are required to comply with the Uniform Federal Accessibility Standards, published by the U.S. Access Board, 1988. Compliance with the provisions of this rule does not substitute for compliance with any applicable provision of the Uniform Federal Accessibility Standards, or any other applicable standards which may be more restrictive than the provisions of this rule.

NOTE: Compliance with the Uniform Federal Accessibility Standards is generally required for buildings and facilities constructed with federal financial assistance.

"Dwelling unit" means a single unit of residence for a household of one or more persons. Examples of a dwelling unit covered by these rules include a condominium, an apartment unit within an apartment building, and another type of dwelling in which sleeping accommodations are provided but toilet or cooking facilities are shared by occupants of more than one room or portion of the dwelling. Examples of the latter include dormitory rooms and sleeping accommodations in shelters intended for occupancy as a residence for homeless persons.

"Ground floor" means a floor of a building with a building entrance on an accessible route. A building may have one or more ground floors. Where the first floor containing dwelling units in a building is above grade, all units on that floor must be served by a building entrance on an accessible route. This floor will be considered to be a ground floor.

a. The individual dwelling units shall contain an accessible route into and through the unit.

(1) All doors intended for use as passage through the dwelling unit shall have a clear opening of at least 32″ nominal width with the door open 90 degrees, measured between the face of the door and the stop. Openings more than 24″ in depth are not considered doorways.

NOTE: A 34″ door, hung in the standard manner, provides an acceptable 32″ opening.

(2) Except at doorways, the minimum clear width of the accessible route shall be at least 36″ wide.

(3) In single-story units, special features such as lofts or sunken or raised areas are not required to be on an accessible route provided the areas do not interrupt the accessible route through the remainder of the dwelling unit.

(4) In multistory dwelling units in buildings with elevators, the story of the unit that is served by the building elevator shall be the primary entry to the unit and such entry/accessible floor shall comply with the requirements of subparagraphs (1), (2) and (3) above. The entry/accessible floor shall contain a bathroom or powder room which complies with paragraph *"c"* below.

(5) Exterior deck, patio, or balcony surfaces shall be no more than ½″ below the floor level of the interior of the dwelling unit, unless they are constructed of impervious material such as concrete, brick or flagstone. In such case, the surface shall be no more than 4″ below the floor level of the interior or lower if required by local building code.

(6) Thresholds at exterior doors, including sliding tracks, shall be no higher than ¾″. Thresholds and changes in elevations as in subparagraph (5) above shall be beveled with a slope no greater than 1:2.

b. Kitchens shall meet or be adaptable to meet the following:

(1) A clear floor space at least 30″ × 48″ that allows a parallel approach by a person in a wheelchair must be provided at the range or cooktop and the sink. Either a parallel or forward approach must be provided at the oven, dishwasher, refrigerator/freezer or trash compactor.

(2) Clearance between counters and all opposing base cabinets, countertops, appliances or walls must be at least 40″. In U-shaped kitchens with a sink or cooktop at the base of the "U," the base cabinets must be removable at that location or a 60″ turning radius must be provided.

c. All bathrooms of covered multifamily dwelling units shall comply with provisions of subparagraph (1) of this paragraph or at least one bathroom in the dwelling unit shall comply with provisions of subparagraph (2) of this paragraph and all other bathrooms and powder rooms within the dwelling unit must be on an accessible route with usable entry doors in accordance with paragraph *"a"* above.

However, in multistory dwelling units, only those bathrooms on the accessible level are subject to these requirements. Where the powder room is the only facility provided on the accessible level of a multistory dwelling unit, the powder room must comply with the provisions of subparagraph (1) or (2) of this paragraph.

(1) Sufficient maneuvering space shall be provided within the bathroom for a person using a wheelchair or other mobility aid to enter and close the door, use the fixtures, reopen the door and exit. Doors may swing into the clear floor space provided at any fixture if the maneuvering space is provided. Maneuvering space may include any knee space or toe space available below the bathroom fixtures.

Clear floor space at fixtures may overlap.

If the shower stall is the only bathing facility provided in the covered dwelling unit, the shower stall shall measure at least 36″ × 36″.

NOTE: Cabinets under lavatories are acceptable provided the bathroom has space to allow a parallel approach by a person in a wheelchair; if parallel approach is not possible within the space, any cabinets provided would have to be removable to afford the necessary knee clearance for forward approach.

(2) Where the door swings into the bathroom, there shall be a clear space (2′6″ × 4′0″) within the room to position a wheelchair or other mobility aid clear of the path of the door as it is closed and to permit the use of the fixtures. This clear space can include any knee space and toe space available below the bathroom fixtures.

Where the door swings out, a clear space shall be provided within the bathroom for a person using a wheelchair or other mobility aid to position the wheelchair such that the person is allowed use of the fixtures. There also shall be a clear space to allow persons using wheelchairs to reopen the door to exit.

When both tub and shower fixtures are provided in the bathroom, at least one fixture shall be made accessible. When two or more lavatories are provided in a bathroom, at least one shall be made accessible.

Toilets shall be located within bathrooms in a manner that permits a grab bar to be installed on one side of the fixture. In locations where toilets are adjacent to walls or bathtubs, the centerline of the fixture shall be a minimum of 1′6″ from the obstacle. The other (nongrab bar) side of the toilet fixture shall be a minimum of 1′3″ from the finished surface of the adjoining walls, vanities, or the edge of a lavatory.

Vanities and lavatories shall be installed with the center line of the fixture a minimum of 1′3″ horizontally from an adjoining wall or fixture. The top of the fixture rim is a maximum height of 2′10″ above the finished floor. If knee space is provided below the vanity, the bottom of the apron is at least 2′3″ above the floor. If provided, full knee space (for front approach) is at least 1′5″ deep.

Bathtubs and tub/showers located in the bathroom shall provide a clear access aisle adjacent to the lavatory that is at least 2′6″ wide and extends for a length of 4′0″ (measured from the head of the bathtub).

Stall showers in the bathroom may be of any size or configuration. A minimum clear floor space 2′6″ wide × 4′0″ deep should be available outside the stall. If the shower stall is the only bathing facility provided in the covered dwelling unit, or on the accessible level of a covered multistory unit, and measures a nominal 36″ × 36″, the shower stall must have reinforcing to allow for installation of an optional wall-hung bench seat.

d. Walls in bathrooms which are to be adaptable shall be reinforced to allow later installation of grab bars around toilet, tub, shower stall and shower seat where provided.

Where the toilet is not placed adjacent to a side wall, provision shall be made for floor-mounted foldaway or similar alternative grab bars. Where the powder room is the only toilet facility located on an accessible level of a multistory dwelling unit, it must comply with this requirement for reinforced walls for grab bars. “Powder room” means a room with a toilet and sink.

NOTE: A tub may have shelves or benches at either end; or a tub may be installed without surrounding walls, if there is provision for alternative mounting of grab bars. For example, a sunken tub placed away from walls could have reinforced areas for installation of floor-mounted grab bars. The same principle applies to shower stalls, e.g., glass-walled stalls could be planned to allow floor-mounted grab bars to be installed later.

Reinforcement for grab bars may be provided in a variety of ways (for example, by plywood or wood blocking) so long as the necessary reinforcement is placed so as to permit later installation of appropriate grab bars.

e. Public and common use areas shall be readily accessible to and usable by persons with disabilities.

f. Light switches, electrical outlets, thermostats and other environmental controls shall be located no higher than 48″, and no lower than 15″, above the floor. If the reach is over an obstruction (for example, an overhanging shelf) between 20″ and 25″ in depth, the maximum height is reduced to 44″ for forward approach; or 46″ for side approach, provided the obstruction (for example, a kitchen base cabinet) is no more than 24″ in depth. Obstructions should not extend more than 25″ from the wall beneath a control. (See ADAAG Figure 5.)

NOTE: Controls or outlets that do not satisfy these specifications are acceptable provided that comparable controls or outlets (i.e., that perform the same functions) are provided within the same area and are accessible.

302.20(2) Elevators. An elevator shall be required in any apartment building of four or more stories. An elevator required by this subrule shall meet the requirements established for accessible elevators in rule 661—302.5(103A,104A), which adopts by reference section 4.10 of the Americans with Disabilities Act Accessibility Guidelines (28 CFR Part 36, Appendix A).

NOTE: Elevators are not required in apartment buildings of three or fewer stories; however, the Uniform Federal Accessibility Standards, or any other applicable standard, may require the installation of an elevator. If an elevator is not required to be installed by this rule, then the elevator is not subject to the requirements of rule 661—302.5(103A,104A).

302.20(3) Any covered units within a multiple unit dwelling which comply with a code or standard which has been certified as a safe harbor for compliance with the accessibility requirements of the federal Fair Housing Act by the U.S. Department of Housing and Urban Development shall be deemed to be in compliance with rule 661—302.20(103A,104A), unless the covered units are required to comply with the Uniform Federal Accessibility Standards or any other applicable requirements which may be more restrictive than the provisions of this rule.

Rule 661—302.20(103A,104A) is intended to implement Iowa Code sections 103A.7(5) and 104A.2.

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CHAPTER 551
ELECTRICAL INSPECTION PROGRAM—DEFINITIONS

661—551.1(103) Applicability. The definitions provided in this chapter apply to 661—Chapters 550 through 559, inclusive.

661—551.2(103) Definitions. The following definitions apply to the electrical inspection program:

"Apprentice electrician" means any person who, as such person's principal occupation, is engaged in learning and assisting in the installation, alteration, and repair of electrical wiring, apparatus, and equipment as an employee of a person licensed under this chapter, and who is licensed by the board and is progressing toward completion of an apprenticeship training program registered by the Bureau of Apprenticeship and Training of the United States Department of Labor. For purposes of this chapter, persons who are not engaged in the installation, alteration, or repair of electrical wiring, apparatus, and equipment, either inside or outside buildings, shall not be considered apprentice electricians.

"Board" means the electrical examining board created under Iowa Code Supplement section 103.2.

"Class A journeyman electrician" means a person having the necessary qualifications, training, experience, and technical knowledge to wire for or install electrical wiring, apparatus, and equipment and to supervise apprentice electricians and who is licensed by the board.

"Class A master electrician" means a person having the necessary qualifications, training, experience, and technical knowledge to properly plan, lay out, and supervise the installation of electrical wiring, apparatus, and equipment for light, heat, power, and other purposes and who is licensed by the board.

"Class B journeyman electrician" means a person having the necessary qualifications, training, experience, and technical knowledge to wire for or install electrical wiring, apparatus, and equipment and who meets and is subject to the requirements of Iowa Code Supplement section 103.12.

"Class B master electrician" means a person having the necessary qualifications, training, experience, and technical knowledge to properly plan, lay out, and supervise the installation of electrical wiring, apparatus, and equipment and who meets and is subject to the requirements of Iowa Code Supplement section 103.10.

"Commercial installation" means an installation intended for commerce, but does not include a residential installation. [See Objection at end of chapter]

"Electrical contractor" means a person affiliated with an electrical contracting firm or business who is licensed by the board as either a class A or class B master electrician and who is also registered with the state of Iowa as a contractor.

"Emergency installation" means an electrical installation necessary to restore power to a building or facility when existing equipment has been damaged due to a natural or man-made disaster or other weather-related cause. Emergency installations may be performed by persons properly licensed to perform the work, and may be performed prior to submission of a request for permit or request for inspection. A request for permit and request for inspection, if required by rule 661—552.1(103), shall be made as soon as practicable and, in any event, no more than 72 hours after the installation is completed.

"Farm" means land, buildings and structures used for agricultural purposes including but not limited to the storage, handling, and drying of grain and the care, feeding, and housing of livestock.

"Industrial installation" means an installation intended for use in the manufacture or processing of products involving systematic labor or habitual employment and includes installations in which agricultural or other products are habitually or customarily processed or stored for others, either by buying or reselling on a fee basis.

"Inspector" means a person certified as an electrical inspector upon such reasonable conditions as may be adopted by the board. The board may recognize more than one class of electrical inspectors.

"New electrical installation" means the installation of electrical wiring, apparatus, and equipment for light, heat, power, and other purposes.

"Public use building or facility" means any building or facility designated for public use, including all property owned and occupied or designated for use by the state of Iowa.

"Residential electrical work" means electrical work in a residence in which there are no more than four living units within the same building and includes work to connect and work within accessory structures, which are structures no greater than 3,000 square feet in floor area, not more than two stories in height, the use of which is incidental to the use of the dwelling unit or units, and located on the same lot as the dwelling unit or units.

"Routine maintenance" means the repair or replacement of existing electrical apparatus or equipment of the same size and type for which no changes in wiring are made. Routine maintenance by itself does not require an electrical inspection.

"Special electrician" means a person having the necessary qualifications, training, and experience in wiring or installing special classes of electrical wiring, apparatus, equipment, or installations which shall include irrigation system wiring, disconnecting and reconnecting existing air conditioning and refrigeration, and sign installation and who is licensed by the board.

"Unclassified person" means any person, other than an apprentice electrician or other person licensed under this chapter, who, as such person's principal occupation, is engaged in learning and assisting in the installation, alteration, and repair of electrical wiring, apparatus, and equipment as an employee of a person licensed under this chapter, and who is licensed by the board as an unclassified person. For purposes of this chapter, persons who are not engaged in the installation, alteration, or repair of electrical wiring, apparatus, and equipment, either inside or outside buildings, shall not be considered unclassified persons.

"Volunteer emergency service provider" means a volunteer fire fighter as defined in Iowa Code section 85.61, a volunteer emergency rescue technician as defined in Iowa Code section 147A.1, or a reserve peace officer as defined in Iowa Code section 85.61.

[**ARC 8396B**, IAB 12/16/09, effective 2/1/10; **ARC 9626B**, IAB 7/27/11, effective 9/1/11]

These rules are intended to implement 2007 Iowa Acts, chapter 197.

[Filed 10/29/08, Notice 9/24/08—published 11/19/08, effective 1/1/09]

[Filed ARC 8396B (Notice ARC 8160B, IAB 9/23/09), IAB 12/16/09, effective 2/1/10]

[Filed ARC 9626B (Notice ARC 9515B, IAB 5/18/11), IAB 7/27/11, effective 9/1/11]

[Editorial change: IAC Supplement 2/8/12]

OBJECTION

TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

January 23, 2012

Commissioner Larry Noble
Iowa Department of Public Safety
Department of Public Safety Headquarters Building
215 E . 7th Street
Des Moines, IA 50319

Dear Commissioner Noble:

I object to the portions of Iowa Admin. Code r. 661-551.2 and 661-552.1 which regulate electrical installations on farms as defined in Iowa Code §103.1. These filings were adopted by the Electrical Examining Board and published as part of ARC 7346B in XXXI IAB 11 (11-19-2008) and ARC 8396B in XXXII IAB 13 (12-16-2009), respectively.

The Electrical Examining Board has gone beyond their statutory authority. Iowa Code chapter 103 does not grant authority to the Electrical Examining Board to adopt rules to regulate electrical installations on farms by requiring a request for an inspection, a permit and/or an inspection. I find that the Electrical Examining Board went beyond the authority delegated to the agency when it included farm electrical installations within the definition of a "commercial installation" in Iowa Admin. Code r. 661-551.2. I further object to that portion of the third sentence of EXCEPTION 1 to Iowa Admin. Code r. 661-552.1(1) which requires a state electrical permit and/or an electrical inspection for a farm electrical installation as it is beyond the delegated authority of the agency.

The permit and inspection requirements for electrical installations on farms are unreasonable, arbitrary and capricious for several reasons. These rules increase the regulatory burden on farms and farmers. This power-grab by the Electrical Examining Board hurts hard-working Iowa farmers. It leads to unwanted government intrusion. It imposes the very costs on farmers that the legislature intended to protect them from when it created common-sense exemption for farmers. (2007 Iowa Acts, chapter 197). This rule hurts the opportunity of hard-working Iowa farmers to earn a living, free from undue bureaucratic interference. These over-reaching rules harm economic opportunities in agriculture and job growth in Iowa.

STATE CAPITOL DES MOINES, IOWA 50319 515.281.5211 FAX 515.281.6611 WWW.GOVERNOR.IOWA.GOV

The portions of the Iowa Administrative Code r. 661-551.2 and 661-552.1 as described herein, are deemed to be unreasonable, arbitrary, capricious, or otherwise beyond the authority delegated to the agency. This letter constitutes notification of my objection to the above referenced rules as required by Iowa Code §17A.4(6).

Certified as a true and correct copy of my objection this 23rd day of January 2012, by:

Terry E. Branstad, Governor

cc: Electrical Examining Board
Administrative Code Editor

Objection filed January 23, 2012

CHAPTER 552
ELECTRICAL INSPECTION PROGRAM—PERMITS AND INSPECTIONS

661—552.1(103) Required permits and inspections.

552.1(1) Permits and inspections are required for any of the following electrical installations that are initiated on or after February 1, 2009:

a. All new electrical installations for commercial or industrial applications, including installations both inside and outside buildings, and for public-use buildings and facilities and any installation at the request of the owner.

b. All new electrical installations for residential applications in excess of single-family residential applications.

c. All new electrical installations for single-family residential applications requiring new electrical service equipment.

d. Any existing electrical installation observed during inspection which constitutes an electrical hazard. Existing installations shall not be deemed to constitute electrical hazards if the wiring was originally installed in accordance with the electrical code in force at the time of installation and has been maintained in that condition.

e. Inspections of alarm system installations, rules for which are intended to be adopted as new 661—Chapter 560.

EXCEPTION 1:[See Objection at end of chapter] Installations in political subdivisions which perform electrical inspections and which are inspected by the political subdivision are not required to be inspected by the state electrical inspection program. Any installation which is subject to inspection and is on property owned by the state or an agency of the state shall be inspected by the state electrical inspection program. An electrical installation on a farm which is located outside the corporate limits of any municipal corporation (city) shall not be inspected by a political subdivision, shall require a state electrical permit, and may be subject to a state electrical inspection, unless the installation is subject to Exception 2 or Exception 3.

EXCEPTION 2: Any electrical work which is limited to routine maintenance shall not require an inspection.

EXCEPTION 3: Neither a permit nor an inspection is required for an electrical installation which meets all of the following criteria:

1. The installation is legally performed by a master electrician, journeyman electrician, or apprentice electrician working under the direct supervision of a master or journeyman electrician.
2. The installation to be performed does not in any way involve work within an existing or new switchboard or panel board.
3. The installation to be performed does not involve over-current protection of more than 30 amperes.
4. The installation to be performed does not involve any electrical line-to-ground circuit of more than 277 volts, single phase.

552.1(2) The owner of a property on which multiple electrical installations may be performed during a 12-month period may apply for an annual permit to cover all such installations. The holder of an annual permit shall maintain a log of all installations performed pursuant to the annual permit. The owner shall cause the electrical inspection program to be notified of any such installation requiring an inspection and shall be subject to fees for such inspections as though an individual permit had been issued for each installation requiring an inspection. The fee for an annual permit shall be $100. The log shall be available to an electrical inspector on the request of the inspector.

[**ARC 8396B**, IAB 12/16/09, effective 2/1/10]

661—552.2(103) Request for inspection. Prior to commencement of any electrical installation requiring an inspection, the person making such installation shall notify the electrical inspection program of the installation by applying for a permit, unless the installation is covered by an annual

permit issued pursuant to subrule 552.1(2), and shall request an inspection of the installation through one of the following methods:

552.2(1) An inspection may be requested by completing and electronically submitting a Request for Permit form, available on the Web site of the electrical inspection program. Payment of the permit and inspection fees shall be submitted with the form in accordance with the instructions on the electrical inspection section Web site.

NOTE: The Web site to obtain, complete, and submit a Request for Permit form is, as of October 29, 2008: www.dps.state.ia.us/fm/electrical/inspection/.

552.2(2) An inspection may be requested by completing a Request for Inspection form and mailing it to the electrical inspection section as provided in rule 661—550.2(103). The Request for Inspection form may be obtained upon request to the electrical inspection section or from the Web site of the electrical inspection program. If a Request for Inspection form is submitted by mail, it shall be postmarked no less than seven days prior to the commencement of the installation.

552.2(3) An inspection may be requested by completing a Request for Inspection form and submitting it by fax transmission to the electrical inspection section at (515)725-6151. The Request for Inspection form may be obtained upon request to the electrical inspection section or from the Web site of the electrical inspection program.

[**ARC 8396B**, IAB 12/16/09, effective 2/1/10]

661—552.3(103) Scheduling of inspections. Subject to the availability of electrical inspectors, the electrical inspector whose territory includes the location of a requested inspection shall schedule the requested inspection to be completed within three business days of the receipt of the request. If an inspection for which a timely request has been made is not completed within three business days of the completion of the installation, a licensee who completed the installation may energize any new circuits included in the installation, although the installation remains subject to condemnation and disconnection if found to be out of compliance with any applicable provision of 661—Chapter 504 when inspected.

661—552.4(103) Report of inspection. After the completion of an inspection, the inspector shall issue an inspection report on a form prescribed by the board. The report shall indicate the results of the inspection, which may be any of the following:

552.4(1) *Approval.* If the inspector finds that the installation is in compliance with applicable requirements, the inspector shall issue a report indicating that the installation is approved.

552.4(2) *Order of correction.* If the inspector finds that the installation is not in compliance with applicable requirements but does not present an imminent threat to the health or safety of any person, the inspector shall issue an order of correction, prescribing a time frame during which corrective action shall be taken by the licensee responsible for the installation to bring the installation fully into compliance.

552.4(3) *Order of disconnection.* If the inspector finds that the installation is not in compliance with applicable requirements and presents an imminent threat to the health or safety of any person, the inspector shall issue an order of disconnection, requiring that the installation be disconnected until corrective action has been taken which brings the installation into full compliance with applicable requirements. The installation shall not be reconnected until corrective action has been completed and the corrected installation has been approved by an inspector as in compliance with all applicable requirements. The inspector issuing an order of disconnection shall notify the utility providing electrical service to the location of the order and shall notify the utility when the order of disconnection is no longer effective.

661—552.5(103) Appeals. An order of correction or an order of disconnection may be appealed. However, an order of disconnection shall be complied with immediately, and the installation shall not be reconnected pending the outcome of the appeal.

552.5(1) A person who has received an order of correction or disconnection may request an informal appeal to the chief electrical inspector within 14 days of receiving the order by contacting the electrical inspection section by telephone, fax, E-mail, or mail. The informal appeal may be heard in any manner

agreed to by the person filing the appeal and the chief electrical inspector. If the order is upheld by the chief electrical inspector, the person receiving the order may file a formal appeal pursuant to subrule 552.5(2).

552.5(2) A person who has received an order of correction or disconnection may file a request for a formal appeal to the board within 30 days of receiving the order or, if the person has filed a request for an informal appeal, within 30 days of having been notified that the chief electrical inspector has upheld the order. Formal appeals shall be processed as provided in 661—Chapter 10, except that wherever "commissioner" or "department of public safety" appears in those rules, "electrical examining board" shall be substituted.

These rules are intended to implement 2007 Iowa Acts, chapter 197.

[Filed 10/29/08, Notice 9/24/08—published 11/19/08, effective 1/1/09]
[Filed emergency 11/23/08—published 12/17/08, effective 1/1/09]
[Filed ARC 8396B (Notice ARC 8160B, IAB 9/23/09), IAB 12/16/09, effective 2/1/10]
[Editorial change: IAC Supplement 2/8/12]

OBJECTION

TERRY E. BRANSTAD
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KIM REYNOLDS
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January 23, 2012

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Certified as a true and correct copy of my objection this 23rd day of January 2012, by:

Terry E. Branstad, Governor

cc: Electrical Examining Board
Administrative Code Editor

Objection filed January 23, 2012

SECRETARY OF STATE[721]

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[Prior to 7/13/88, see Secretary of State[750], Ch 11]

DIVISION I
GENERAL ADMINISTRATIVE PROCEDURES

721—21.1(47) Emergency election procedures. The state commissioner of elections may exercise emergency powers over any election being held in a district in which either a natural or other disaster or extremely inclement weather has occurred. The state commissioner may also exercise emergency powers during an armed conflict involving United States armed forces, or mobilization of those forces, or if an election contest court finds that there were errors in the conduct of an election making it impossible to determine the result.

21.1(1) *Definitions.*

"Commissioner" means the county commissioner of elections.

"Election contest court" means any of the courts specified in Iowa Code sections 57.1, 58.4, 61.1, 62.1 and 376.10.

"Extremely inclement weather" means a natural occurrence, such as a rainstorm, windstorm, ice storm, blizzard, tornado or other weather conditions, which makes travel extremely dangerous or which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Natural disaster" means a natural occurrence, such as a fire, flood, blizzard, earthquake, tornado, windstorm, ice storm, or other events, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"Other disaster" means an occurrence caused by machines or people, such as fire, hazardous substance or nuclear power plant accident or incident, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

"State commissioner" means the state commissioner of elections.

21.1(2) *Notice of natural or other disaster or extremely inclement weather.* The county commissioner of elections, or the commissioner's designee, may notify the state commissioner of elections that due to a natural or other disaster or extremely inclement weather an election cannot safely be conducted in the time or place for which the election is scheduled to be held. If the commissioner or the commissioner's designee is unable to transmit notice of the hazardous conditions, the notice may be given by any elected county official. Verification of the commissioner's agreement with the severity of the conditions and the danger to the election process shall be transmitted to the state commissioner as soon as possible. Notice may be given by telephone or by facsimile machine, but a signed notice shall also be delivered to the state commissioner.

21.1(3) *Declaration of emergency due to natural or other disaster or extremely inclement weather.* After receiving notice of hazardous conditions, the state commissioner of elections, or the state commissioner's designee, may declare that an emergency exists in the affected precinct or precincts. A copy of the declaration of the emergency shall be provided to the commissioner.

21.1(4) *Emergency modifications to conduct of elections.* When the state commissioner of elections has declared that an emergency exists due to a natural or other disaster or to extremely inclement weather, the county commissioner of elections, or the commissioner's designee, shall consult with the state commissioner to develop a plan to conduct the election under the emergency conditions. All modifications to the usual method for conducting elections shall be approved in advance by the state commissioner unless prior approval is impossible to obtain.

Modifications may be made to the method for conducting the election including relocation of the polling place, postponement of the hour of opening the polls, postponement of the date of the election if no candidates for federal offices are on the ballot, reduction in the number of precinct election officials in nonpartisan elections, or other reasonable and prudent modifications that will permit the election to be conducted.

21.1(5) *Relocation of polling place.* The substitute polling place shall be as close as possible to the usual polling place and shall be within the same precinct if possible. Preference shall be given to buildings which are accessible to the elderly and disabled. Buildings supported by taxation shall be made available without charge by the authorities responsible for their administration. If it is necessary, more than one precinct may be located in the same room.

A notice of the location of the substitute polling place shall be posted on the door of the former polling place not later than one hour before the scheduled time for opening the polls or as soon as possible. If it is unsafe or impossible to post the sign on the door of the former polling place, the notice shall be posted in some other visible place at or near the site of the former polling place. If time permits, notice of the relocation of the polling place shall be published in the same newspaper in which notice of election was published, otherwise notice of relocation may be published in any newspaper of general circulation in the political subdivision which will appear on or before election day. The commissioner shall inform all broadcast media and print news organizations serving the jurisdiction of the modifications.

21.1(6) *Postponement of election.* An election, other than an election at which a federal office appears on the ballot, may be postponed until the following Tuesday. If the election involves more than one precinct, the postponement must include all precincts within the political subdivision. If the election is postponed, ballots shall not be reprinted to reflect the modification in the election date. The date of the close of voter preregistration by mail for the election shall not be extended. Precinct election registers prepared for the original election date may be used or reprinted at the commissioner's discretion.

On the day that the postponed election is actually held, all election day procedures must be repeated.

21.1(7) *Absentee voting in postponed elections.* Absentee ballots shall be delivered to voters pursuant to Iowa Code section 53.22 until the date the election is actually held. Absentee ballots shall be accepted at the commissioner's office until the hour the polls close on the date the election is held. Absentee ballots which are postmarked no later than the day before the election is actually held shall be accepted if received no later than the time prescribed by the Iowa Code for the usual conduct of the election. The time shall be calculated from the date on which the election is held, not the date for which the election was originally scheduled. However, if absentee ballots have been tabulated before the election is postponed, the absentee ballots shall be sealed in an envelope by the absentee and special voters precinct board and stored securely until the date the election is actually held. The sealed envelopes shall be opened by the absentee and special voters precinct board on the date the election is actually held, counters on the tabulating equipment (if any) shall be reset to zero, and all absentee ballots tabulated on the original election date shall be retabulated.

21.1(8) *Absentee and special voters precinct board in postponed elections.* The absentee and special voters precinct board shall meet to consider provisional ballots at the times specified in Iowa Code sections 50.22 and 52.23, calculated from the date the election is held. No absentee ballots shall be counted until the date the election is held.

21.1(9) *Canvass of votes in postponed elections.* The canvass of votes shall also be rescheduled for one week after the originally scheduled canvass date.

21.1(10) *Postponements made on election day.* If the emergency is declared while the polls are open and the decision is made to postpone the election, each precinct polling place in the political subdivision shall be notified to close its doors and to halt all voting immediately. People present in the polling place who are waiting to vote shall not be given ballots. People who have received and marked their ballots shall deposit them in the ballot box; unmarked ballots may be returned to the precinct election officials.

The precinct election officials shall seal all ballots which were cast before the declaration of the emergency in secure containers. The containers shall be clearly marked as ballots from the postponed election. If it is safe to do so, the ballot containers, election register, and other election supplies shall be transported to the commissioner's office. The ballots shall be stored in a secure place. If it is unsafe to travel to the commissioner's office, the chairperson of the precinct election board shall see that the ballots and the election register are securely stored until it is safe to return them to the commissioner. If no contest is pending six months after the canvass for the election is completed, the unopened, sealed ballot containers shall be destroyed.

If automatic tabulating equipment is used, the automatic tabulating equipment shall be closed and sealed without printing the results. Before the date the election is held, the automatic tabulating equipment shall be reset to zero. Documents showing the progress of the count, if any, shall be sealed in an envelope and stored. No one shall reveal the progress of the count. After six months, the sealed envelope containing the vote totals shall be destroyed if no contest is pending.

21.1(11) *Records kept.* The state commissioner of elections shall maintain records of each emergency declaration. The records of emergency declarations for federal elections shall be kept for 22 months, and records for all other elections shall be kept for six months following the election. The records shall include the following information:

a. The county in which the emergency occurred.

b. The date and time the emergency declaration was requested.

c. The name and title of the person making the request.

d. Name and date of the election affected.

e. The jurisdiction for which the election is to be conducted (school, city, county, or other).

f. The number of precincts in the jurisdiction.

g. The number of precincts affected by the emergency.

h. The nature of the emergency, i.e., natural or other disaster, or extremely inclement weather.

i. The date or dates of the occurrence of the natural or other disaster or extremely inclement weather.

j. Conditions affecting the conduct of the election.

k. Whether the polling places may safely be opened on time.

l. Action taken: such as moving the polling place, change voting system, postpone election until the following Tuesday.

m. Method to be used to inform the public of changes made in the election procedure.

n. The signature of the state commissioner or the state commissioner's designee who was responsible for declaring the emergency.

21.1(12) *Federal elections.*

a. If an emergency occurs that will adversely affect the conduct of an election at which candidates for federal office will appear on the ballot, the election shall not be postponed or delayed. Emergency measures shall be limited to relocation of polling places, modification of the method of voting, reduction of the number of precinct election officials at a precinct and other modifications of prescribed election procedures which will enable the election to be conducted on the date and during the hours required by law.

The primary election held in June of even-numbered years and the general election held in November of even-numbered years shall not be postponed. Special elections called by the governor pursuant to Iowa Code section 69.14 shall not be postponed unless no federal office appears on the ballot.

b. If a federal or state court order extends the time established for closing the polls pursuant to Iowa Code section 49.73, any person who votes after the statutory hour for closing the polls shall vote only by casting a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballots cast after the statutory hour for closing the polls shall be sealed in a separate envelope from provisional ballots cast during the statutory polling hours. The absentee and special voters precinct board shall tabulate and report the results of the two sets of provisional ballots separately.

21.1(13) *Military emergencies.* A voter who is entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces," may return an absentee ballot via electronic transmission only if the voter is located in an area designated by the U.S. Department of Defense to be an imminent danger pay area or if the voter is an active member of the army, navy, marine corps, merchant marine, coast guard, air force or Iowa national guard and is located outside the United States or any of its territories. Procedures for the return of absentee ballots by electronic transmission are described in subrule 21.320(4).

21.1(14) *Election contest emergency.* If an election contest court finds that there were errors in the conduct of an election which make it impossible to determine the result of the election, the contest court shall notify the state commissioner of elections of its finding. The state commissioner shall order a repeat

election to be held. The repeat election date shall be set by the state commissioner. The repeat election shall be conducted under the state commissioner's supervision.

The repeat election shall be held at the earliest possible time, but it shall not be held earlier than 14 days after the date the election was set aside. Voter registration, publication, equipment testing and other applicable deadlines shall be calculated from the date of the repeat election.

The repeat election shall be conducted under the same procedures required for the election that was set aside, except that all known errors in preparation and procedure shall be corrected. The nominations from the initial election shall be used in the repeat election unless the contest court specifically rejects the initial nomination process in its findings. Precinct election officials for the repeat election may be replaced at the discretion of the auditor.

The following materials prepared for the original election shall be used or reconstructed for the repeat election:

Ballots (showing the date of repeat election). This may be stamped on ballots printed for the original election.

Notice of election (showing the date of repeat election).

This rule is intended to implement Iowa Code section 47.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—21.2(47) Electronic submission of absentee ballot applications and affidavits of candidacy. Absentee ballot applications and affidavits of candidacy may be submitted electronically using either fax or E-mail.

21.2(1) *Electronic copies of absentee ballot applications and affidavits of candidacy accepted for filing.* Assuming that all other legal requirements are met, absentee ballot applications and affidavits of candidacy required by Iowa Code chapters 43, 44, 45, 161A, 260C, 277, 376 and 420 may be submitted electronically by either fax or E-mail if presented to the appropriate filing officer as an exact copy of the original and if the submission is in compliance with subrule 21.2(2).

21.2(2) *Original absentee ballot applications.* The original absentee ballot application submitted electronically shall also be mailed or delivered to the commissioner. If mailed, the envelope bearing the original absentee ballot application shall be postmarked not later than the Friday before the election. This subrule shall not apply to documents submitted electronically by UOCAVA voters pursuant to rule 721—21.320(53).

a. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the original absentee ballot application which was filed electronically is not received by the time the polls close on election day.

b. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the postmark on the envelope containing the original absentee ballot application is either illegible or later than the Friday before the election.

21.2(3) *Original affidavits of candidacy.* The original copy of an affidavit of candidacy submitted electronically shall also be filed with the appropriate commissioner. The envelope bearing the original affidavit (if any) shall be postmarked not later than the last day to file the document.

a. The filing shall be void if the original affidavit of candidacy filed electronically is not received within seven days after the filing deadline for the original affidavit of candidacy.

b. The filing shall be void if the postmark on the envelope containing the original affidavit of candidacy is later than the filing deadline.

c. If an affidavit of candidacy filing is voided because the original affidavit of candidacy submitted by facsimile machine was postmarked too late or arrives too late, the person who filed the document shall be notified immediately in writing.

This rule is intended to implement Iowa Code sections 43.11, 43.19, 43.54, 43.67, 43.78, 44.3, 45.3, 45.4, 46.20, 47.1, and 47.2; sections 53.2, 53.8, 53.17, 53.22, 53.25, and 53.40 as amended by 2009 Iowa Acts, House File 475; sections 53.45, 61.3, 161A.5, and 277.4; sections 260C.15 and 376.4 as amended by 2009 Iowa Acts, House File 475; and sections 376.11 and 420.130.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9879B**, IAB 11/30/11, effective 1/4/12]

721—21.3(49,48A) Voter identification documents.

21.3(1) *Identification documents for persons other than election day registrants.* Unless the person is registering to vote at the polls on election day, precinct election officials shall accept the identification documents listed in Iowa Code section 48A.8 from any person who is asked or required to present identification pursuant to Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

21.3(2) *Identification for election day registrants.*

a. A person who applies to register to vote on election day shall provide proof of identity and residence pursuant to Iowa Code section 48A.7A in the precinct where the person is applying to register and vote.

b. Any registered voter who attests for another person registering to vote at the polls on election day shall be a registered voter of the same precinct. The registered voter may be a precinct election official or a pollwatcher, but may not attest for more than one person applying to register at the same election.

21.3(3) *Current and valid identification.*

a. "Current and valid" or "identification," for the purposes of this rule, means identification that meets the following criteria:

(1) The expiration date on the identification has not passed. An identification is still valid on the expiration date. An Iowa nonoperator's identification that shows "none" as the expiration date shall be considered current and valid.

(2) The identification has not been revoked or suspended.

b. A current and valid identification may include a former address.

21.3(4) *Identification not provided.* A person who has been requested to provide identification and does not provide it shall vote only by provisional ballot pursuant to Iowa Code section 49.81. However, a person who is registering to vote on election day pursuant to Iowa Code section 48A.7A may establish identity and residency in the precinct by written oath of a person who is registered to vote in the precinct.

This rule is intended to implement Iowa Code section 48A.7A and section 49.77 as amended by 2009 Iowa Acts, House File 475, and P.L. 107-252, Section 303.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.4(49) Changes of address at the polls. An Iowa voter who has moved from one precinct to another in the county where the person is registered to vote may report a change of address at the polls on election day.

21.4(1) To qualify to vote in the election being held that day, the voter shall:

a. Go to the polling place for the precinct where the voter lives on election day.

b. Complete a registration form showing the person's current address in the precinct.

c. Present proof of identity as required by subrule 21.3(1).

21.4(2) The officials shall require a person who is reporting a change of address at the polls to cast a provisional ballot if the person's registration in the county cannot be confirmed. Registration may be confirmed by:

a. Telephoning the office of the county commissioner of elections, or

b. Reviewing a printed list of all registered voters who are qualified to vote in the county for the election being held that day, or

c. Researching the county's voter registration records using a computer.

21.4(3) In precincts where the voter's declaration of eligibility is included in the election register pursuant to rule 721—21.5(49) and Iowa Code section 49.77, the commissioner shall provide to each precinct one of the two following methods for recording changes of address:

a. The voter shall be given both an eligibility declaration and a voter registration form. The eligibility declaration may be printed on the same piece of paper as the voter registration form.

b. The commissioner shall provide blank lines on the election register for the precinct election officials to record the voter's name, address, and, if provided, telephone number, and, in primary

elections, political party affiliation. The voter shall sign the election register next to the printed information. The voter shall also complete a voter registration form showing the voter's current address.

This rule is intended to implement Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.5(49) Eligibility declarations in the election register. To compensate for the absence of a separate declaration of eligibility form, the commissioner shall provide to each precinct a voter roster with space for each person who appears at the precinct to vote to print the following information: first and last name, address, and, at the voter's option, telephone number, and, in primary elections, political party affiliation.

The roster forms shall include the name and date of the election and the name of the precinct, and may be provided on paper that makes carbonless copies. If a multicopy form is used, the commissioner shall retain the original copy of the voter roster with other records of the election.

This rule is intended to implement Iowa Code section 49.77.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.6(43,50) Turnout reports. Rescinded IAB 6/2/10, effective 7/1/10.

721—21.7(48A) Election day registration. In addition to complying with the identification provisions in rule 721—21.3(49,48A), precinct election officials shall comply with the following requirements:

21.7(1) Precinct election officials shall inspect the identification documents presented by election day registrants to verify the following:

a. The photograph shows the person who is registering to vote.

b. The name on the identification document is the same as the name of the applicant.

c. The address on the identification document is in the precinct where the person is registering to vote.

21.7(2) Precinct election officials shall verify that each person who attempts to attest to the identity and residence of a person who is registering to vote on election day is a registered voter in the precinct and has not attested for any other voter in the election. The officials shall note in the election register that the person has attested for an election day registrant.

21.7(3) Precinct election officials shall permit any person who is in line to vote at the time the polls close to register and vote on election day if the person otherwise meets all of the election day registration requirements.

21.7(4) In precincts where an electronic program is not used to check the name of an election day registrant against the statewide list of felons who have had their right to vote revoked, precinct election officials shall provide each election day registrant with a "Notice to Election Day Registrants" prepared by the state commissioner before allowing the voter to register and vote on election day. The "Notice to Election Day Registrants" prepared by the state commissioner will be posted on the state commissioner's Web site.

This rule is intended to implement 2007 Iowa Acts, House File 653.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8777B**, IAB 6/2/10, effective 5/7/10]

721—21.8(48A) Notice to election day registrant. The commissioner shall send to each person who registers to vote on election day, pursuant to Iowa Code section 48A.7A, an acknowledgment of the registration by nonforwardable mail. If the postal service returns the acknowledgment as undeliverable, the commissioner shall send a notice to the voter by forwardable mail. The notice shall be substantially in the form titled "Notice to Election Day Registrant" posted on the state commissioner's Web site.

This rule is intended to implement Iowa Code sections 48A.7A and 48A.26A.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.9(49) "Vote here" signs.

1. Size. The signs shall be no smaller than 16 inches by 24 inches.

2. Exceptions. If a driveway leads away from the entrance to the voting area, or if the driveway is located in such a way that posting a "vote here" sign at the driveway entrance would not help potential voters find the voting area, no "vote here" sign shall be posted at the entrance to that driveway.

This rule is intended to implement Iowa Code section 49.21.

721—21.10(43) Application for status as a political party. A political organization which is not currently qualified as a political party may file an application for determination of political party status with the state commissioner of elections. The application may be filed after the completion of the executive council's canvass of votes for the general election, but not later than one year after the date of the election at which the organization's candidate for President of the United States or governor received at least 2 percent of the vote.

21.10(1) *Application form.* The application shall be substantially in the form titled "Application for Political Party Status" posted on the state commissioner's Web site.

21.10(2) *Response.* If the political organization meets the requirements established in Iowa Code section 43.2, the commissioner shall declare that the organization has qualified as a political party, effective 21 days after the application is approved. If the organization does not meet the requirements, the state commissioner shall immediately notify the applicant in writing of the reason for the rejection of the application.

21.10(3) *Disqualification of political party.* If at the close of nominations for the general election a political party has not nominated a candidate for the office of President of the United States, or for governor, as the case may be, the political party shall be disqualified immediately.

If the candidate of a political party for President of the United States or for governor, as the case may be, does not receive 2 percent of the votes cast for that office at a general election, the political party shall be disqualified. The effective date of the disqualification shall be the date of the completion of the state canvass of votes.

When a political party is disqualified, the state commissioner shall immediately notify the chairperson or central committee of the disqualified political party.

21.10(4) *Notice of qualification and disqualification of political parties.* The state commissioner of elections shall immediately notify the state registrar of voters, the voter registration commission, and the county commissioners of elections when a political party is qualified or disqualified. The notice shall include the name of the political party and the date upon which change in political party status becomes effective.

The state commissioner of elections shall also publish notice of the qualification or disqualification of a political party in a newspaper of general circulation in each congressional district. The publication shall be made within 30 days of the approval of an application for qualification or within 30 days of the effective date of a disqualification.

This rule is intended to implement Iowa Code sections 43.2 and 47.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.11(49) Statement to provisional voter. Each voter who is required to vote a provisional ballot at the polls on election day shall be given a statement from the precinct election officials which shall be in substantially the following form:

Statement to Person Casting a Provisional Ballot
(To be completed by Precinct Official and given to Voter)

Voter's Name: _____

Reason for Provisional Ballot (check all that apply):

☐ Voter did not have proper identification (see "What you need to provide" below)
☐ Absentee voter with no ballot to surrender

☐ Voter was challenged by another registered voter
Reason: _____

What you need to provide before your ballot will count:

☐ Photo ID that has not expired and contains your name and picture
☐ One of the following that has not expired: Iowa driver's license, out-of-state driver's license, non-driver ID, U.S. passport, U.S. military ID, ID card issued by an employer, student ID issued by Iowa high school or college
☐ One of the following showing your name and current address: bank statement, paycheck, utility bill, property tax statement, residential lease, government check, or other government document

Deadline: _____a.m./p.m., _____ (date)
Mail or Deliver Evidence to: _____, County Auditor
County Auditor Address: _____
_____

If proof of ID or residence is required, your provisional ballot may be counted if you bring a copy of the identification listed above to this precinct before the polls close today or to the county auditor at the above address by the deadline indicated above. If your ballot is not counted, you will be notified by mail of the reason why it was not counted.

Your right to vote will be reviewed by the Special Precinct Board. You have the right and are encouraged to make a written statement and submit additional written evidence to the Board supporting your qualifications as a registered voter.

_____ _____
Precinct Election Official's Signature Date

This rule is intended to implement Iowa Code section 49.81.
[**ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—21.12 to **21.19** Reserved.

721—21.20(62) Election contest costs. In determining the amount of the bond for election contests, the commissioner shall consider the following aspects of the cost of the election contest proceedings:

1. Fees as provided in Iowa Code section 62.22.
2. Fees for judges as provided in Iowa Code section 62.23.
3. The cost of making an official record of the proceedings.

721—21.21(62) Limitations. The amount of the bond shall not include costs not directly related to the contest court proceedings. Specifically, the amount of the bond shall not be intended to replace any potential lost income to the county caused by the delay in implementing the decision of the voters at the election being contested.

Rules 721—21.20(62) and 721—21.21(62) are intended to implement Iowa Code sections 62.6, 62.22, 62.23, and 62.24.

721—21.22(49) Photocopied ballot procedures. If it is necessary for ballots to be photocopied pursuant to Iowa Code section 49.67, the commissioner shall use the "Request for Additional Ballots" form posted on the state commissioner's Web site to record the request and resolution thereof. The commissioner shall complete the form, including the reason additional ballots are needed; who made the request for additional ballots and what time the request was made; the number of additional ballots produced; the

manner of production of the additional ballots, including location of production; and the commissioner's signature.

This rule is intended to implement Iowa Code section 49.67.

[**ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—21.23 and **21.24** Reserved.

721—21.25(50) Administrative recounts. When the commissioner suspects that voting equipment used in the election malfunctioned or that programming errors may have affected the outcome of the election, the commissioner may request an administrative recount after the day of the election but not later than three days after the canvass of votes. The request shall be made in writing to the board of supervisors explaining the nature of the problem and listing the precincts to be recounted and which offices and questions shall be included in the administrative recount. The board of supervisors shall respond as soon as possible after receipt of the commissioner's request.

The recount shall be conducted by members of the absentee and special voters precinct board following the provisions of Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, Iowa Code section 50.49 and 721—Chapter 26. The commissioner may use different memory cards for the recount and shall retain the information on the memory cards used in the election pursuant to 721—subrule 22.51(13). The commissioner may also use different election definition files if the commissioner believes the original election definition files were flawed. If the commissioner uses different election definition files for the recount, the commissioner shall also retain the election definition files for the election as required by 721—subrule 22.51(14).

This rule is intended to implement Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, and Iowa Code section 50.49.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.26 to **21.29** Reserved.

721—21.30(49) Inclusion of annexed territory in city reprecincting and redistricting plans. If a city has annexed territory after January 1 of a year ending in zero and before the completion of the redrawing of precinct and ward boundaries during a year ending in one, the city shall include the annexed land in precincts drawn pursuant to Iowa Code sections 49.3 and 49.5.

21.30(1) When the city council draws precinct and ward boundaries, if any, the city shall use the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(2) When the board of supervisors, or the temporary county redistricting commission, draws precinct and county supervisor district boundaries, if any, it shall subtract from the population of the adjacent unincorporated area the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(3) The use of population figures for reprecincting or redistricting shall not affect the official population of the city or the county. Only the U.S. Bureau of the Census may adjust the official population figures, by corrections or by conducting special censuses. See Iowa Code section 9F.6.

This rule is intended to implement Iowa Code sections 49.3 and 49.5.

721—21.31(275) School director district maximum allowable deviation between director districts. Each director district shall have a population that exceeds the population of any other director district by no more than 10 percent. Director district plans with variations in excess of 10 percent between two or more districts shall be accompanied by justification for the deviation and shall be rejected by the secretary of state unless the deviation is necessary to comply with one of the other standards enumerated in Iowa Code section 275.23A.

This rule is intended to implement Iowa Code section 275.23A.

[**ARC 9559B**, IAB 6/15/11, effective 5/23/11; **ARC 9891B**, IAB 11/30/11, effective 1/4/12]

721—21.32(372) City ward maximum allowable deviation between city wards. Each city ward shall have a population that exceeds the population of any other city ward by no more than 10 percent. City ward plans with variations in excess of 10 percent between two or more wards shall be accompanied by justification for the deviation and shall be rejected by the secretary of state unless the deviation is necessary to comply with one of the other standards enumerated in Iowa Code section 372.13, subsection 7.

This rule is intended to implement Iowa Code section 372.13.
[**ARC 9559B**, IAB 6/15/11, effective 5/23/11; **ARC 9891B**, IAB 11/30/11, effective 1/4/12]

721—21.33(49) Redistricting special election blackout period. A special election shall not be held on the three Tuesdays preceding and following January 15 of years ending in the number two.

This rule is intended to implement Iowa Code chapter 49.
[**ARC 9893B**, IAB 11/30/11, effective 11/9/11]

721—21.34 to **21.49** Reserved.

721—21.50(49) Polling place accessibility standards.

21.50(1) *Inspection required.* Before any building may be designated for use as a polling place, the county commissioner of elections or the commissioner's designee shall inspect the building to determine whether it is accessible to persons with disabilities.

21.50(2) *Frequency of inspection.* Polling places that have been inspected using the Polling Place Accessibility Survey Form prescribed in subrule 21.50(4) shall be reinspected if structural changes are made to the building or if the location of the polling place inside the building is changed.

21.50(3) *Review of accessibility.* Not less than 90 days before each primary election, the commissioner shall determine whether each polling place needs to be reinspected.

21.50(4) *Standards for determining polling place accessibility.* The survey form available on the state commissioner's Web site titled "Polling Place Accessibility Survey" shall be used to evaluate polling places for accessibility to persons with disabilities.

The term "off-street parking" used in the polling place accessibility survey means parking places in lots separated from the street and includes angle parking along the street if the accessible route from the parking place to the polling place is entirely out of the path of traffic. Parking arrangements that require either the driver or passengers of the vehicle to go into the traveled part of the street are not accessible.

An access aisle at street level that is at least 60 inches wide and the same length as each accessible parking space shall be provided. An accessible public sidewalk curb ramp shall connect the access aisle to the continuous passage to the polling place. At least one parking place shall be van-accessible with a 96-inch access aisle connected to the continuous passage to the polling place by an accessible public sidewalk curb ramp. Two accessible parking spaces may share a common access aisle.

21.50(5) *Temporary waiver of accessibility requirements.* Notwithstanding the waiver provisions of 721—Chapter 10, if the county commissioner is unable to provide an accessible polling place for any precinct, the commissioner shall apply for a temporary waiver of accessibility requirements pursuant to this subrule. Applications shall be filed with the secretary of state not later than 60 days before the date of any scheduled election. If a waiver is granted, it shall be valid for two years from the date of approval by the secretary of state.

a. Each application shall include the following documents:

(1) Application for Temporary Waiver of Accessibility Requirements.

(2) A copy of the Polling Place Accessibility Survey Form for the polling place to be used.

(3) A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for the precinct.

b. If an accessible place becomes available at least 30 days before an election, the commissioner shall change polling places and shall notify the secretary of state. The notice shall include a copy of the Polling Place Accessibility Survey Form for the new polling place.

21.50(6) *Emergency waivers.* During the 60 days preceding an election, if a polling place becomes unavailable for use due to fire, flood, or changes made to the building, or for other reasons, the

commissioner must apply for an emergency waiver of accessibility requirements in order to move the polling place to an inaccessible building. Emergency waiver applications must be filed with the secretary of state as soon as possible before election day. To apply for an emergency waiver, the commissioner shall send the following documents:

a. Application for Temporary Waiver of Accessibility Requirements.

b. A copy of the Polling Place Accessibility Survey Form for the polling place selected.

c. A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for this precinct (if any).

21.50(7) *Application form.* The form posted on the state commissioner's Web site titled "Temporary Waiver of Accessibility Requirements" shall be used to apply for a temporary waiver of accessibility requirements.

21.50(8) *Evaluation of waivers.* When the secretary of state receives waiver applications, the applications shall be reviewed carefully. A response shall be sent to the commissioner within one week by E-mail or by fax to notify the commissioner when the waiver request was received and whether additional information is needed.

21.50(9) *Granting waivers.* If the secretary of state determines from the documents filed with the waiver request that conditions justify the use of a polling place that does not meet accessibility standards, the secretary of state shall grant the waiver of accessibility requirements. If the secretary of state determines from the documents filed with the waiver request that all potential polling places have been surveyed and no accessible place is available, and the available building cannot be made temporarily accessible, the waiver shall be granted.

21.50(10) *Notice required.* Each notice of election published pursuant to Iowa Code section 49.53 shall clearly describe which polling places are inaccessible. The notice shall include a description of the services available to persons with disabilities who live in precincts with inaccessible polling places. The notice shall be in substantially the following form:

Any voter who is physically unable to enter a polling place has the right to vote in the voter's vehicle. For further information, please contact the county auditor's office at the telephone number or E-mail address listed below:

Telephone: _____ E-mail address: _____.

For TTY access, dial 711 + [auditor's office number].

21.50(11) *Denial of waiver requests.* The secretary of state shall review each waiver request. The secretary of state shall consider the totality of the circumstances as shown by the information on the waiver request, information contained in previous applications for waivers for the same precinct and for other precincts in the county, and other relevant available information. The waiver request may be denied if it appears that the commissioner has not made a good-faith effort to find an accessible polling place. If the waiver request is denied, the secretary of state shall notify the commissioner in writing of the reason for denying the request.

This rule is intended to implement Iowa Code section 49.21.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9879B**, IAB 11/30/11, effective 1/4/12]

721—21.51 to **21.74** Reserved.

721—21.75(49) Voting centers for certain elections. The commissioner may establish voting centers for the regular city election, city primary election, city runoff election, regular school election, and special elections.

21.75(1) *Definition.*

"Voting center" means a location established by the commissioner for the purpose of providing ballots to all registered voters who are qualified to vote in a particular jurisdiction for a regular city election, city primary election, city runoff election, regular school election, or special election.

21.75(2) *Minimum requirements.*

a. Establishment. One or more voting centers may be established in lieu of precinct polling places for the elections at which the use of voting centers is permitted. Regular polling place sites that are

accessible to people with disabilities may be used as voting centers for any election at which the use of voting centers is permitted. Other suitable locations may also be used.

b. Location of voting centers. If voting centers are established for an election, at least one voting center must be located within the boundaries of the political subdivision for which the election is being conducted. At the commissioner's discretion, additional vote centers may be established as long as the voting center is located within the boundaries of the political subdivision for which the election is being conducted.

c. Accessibility. A voting center is subject to the requirements of Iowa Code section 49.21 relating to accessibility to persons who are elderly and persons with disabilities and relating to the posting of signs.

21.75(3) *Hours.* Voting center hours shall be the same as permitted for an election pursuant to Iowa Code section 49.73.

21.75(4) *Publications.* The location of each voting center shall be published in the notice of election by the commissioner in the same manner as the location of polling places is required to be published. The notice of election shall also include a description of the voting center in substantially the following form:

For the _____ election to be held on [date], voting centers will be available. Any registered voter of [jurisdiction name] may vote at any of the following places in this election:

[List addresses of voting centers.]

21.75(5) *Posting notices at regular polling places on election day.* If voting centers are established in lieu of regular polling places for an election, the commissioner shall post a notice of voting center locations, not later than the hour at which the polls open on the day of the election, on each door to the usual polling place in the precinct. The notice shall remain posted until the polls have closed.

21.75(6) *I-Voters use prohibited.* The commissioner shall not provide direct access from voting centers to the I-Voters system on election day.

21.75(7) *Determining ballot rotations.* For the purposes of determining ballot rotations pursuant to Iowa Code section 49.31 in an election for which the commissioner has established voting centers, the commissioner may use either precincts established pursuant to Iowa Code sections 49.3 to 49.5 or consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a."* If the commissioner uses consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a,"* the commissioner shall use the same consolidated precincts used in the last regularly scheduled election conducted for the political subdivision in which voting centers were not used.

21.75(8) *Operation of voting centers.*

a. Election registers and voter lists. Each voting center shall have an election register containing the names, addresses and voter statuses of all registered voters who are eligible to vote in that election. The election register may be a paper list or may be available on computers in an electronic format, rather than as an interactive connection to I-Voters.

b. Election day registration at voting centers. A person who needs to register to vote may register and vote at a voting center provided that the person has appropriate identification and is a resident of the jurisdiction served by the voting center.

c. Voters reporting address changes at voting centers. Any person who is already registered in the county and updates the person's voter registration address at a voting center shall show identification listed in Iowa Code section 48A.8. Persons unable to provide requested identification shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

d. Ballots. Each voting center shall have all ballot styles necessary to provide a ballot to any voter who is eligible to vote in the election for the jurisdiction served by the voting center.

e. Precinct election officials. Voting centers shall be administered by a minimum of three precinct election officials selected pursuant to Iowa Code sections 49.12 to 49.16. These officials shall be trained before each election and shall have specific instructions regarding the differences between voting centers and polling places.

f. Ballot boxes used with optical scan voting equipment at voting centers. The commissioner may instruct two precinct election officials not of the same political party to open the ballot box periodically throughout election day to ensure the ballots are stacking evenly in the ballot box to prevent a voting equipment malfunction. The precinct election officials charged with inspecting the ballot box shall ensure the ballot box is locked and secured at all times. As an alternative to this procedure, the commissioner may supply any voting center with additional ballot boxes and the precinct election officials may move the optical scan voting equipment to a new ballot box if necessary. All ballot boxes containing voted ballots shall be locked and secured by the precinct election officials at all times.

21.75(9) *Postelection review of voter participation.*

a. Within 45 days after the election, the commissioner shall review the signed declarations of eligibility or the signed election registers from each voting center, and if any person is found to have voted in more than one voting center in the election, the commissioner shall immediately notify the county attorney.

b. The notice to the county attorney shall include a copy of the person's voter registration record and copies of the declarations of eligibility signed by the voter. The notice shall also include a reference to Iowa Code sections 39A.2(2) and 49.11(3)*"b."*

This rule is intended to implement Iowa Code sections 49.9 and 49.11.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.76 to **21.199** Reserved.

DIVISION II
BALLOT PREPARATION

721—21.200(49) Constitutional amendments and public measures.

21.200(1) The order of placement on the ballot for constitutional amendments and statewide public measures to be voted upon at a single election shall be determined by the state commissioner, and a number shall be assigned to each constitutional amendment or statewide public measure by the state commissioner.

a. The number assigned by the state commissioner to each constitutional amendment or statewide public measure to appear on the ballot for a single election shall be printed on the ballot immediately preceding and above the words "Shall the following amendment to the Constitution (or public measure) be adopted?" or the words "Shall there be a Convention to revise the Constitution, and propose amendment or amendments to same?"

b. The number assigned by the state commissioner shall be printed on the ballot at least 1/8 of an inch high in the designated place.

c. Even if only one constitutional amendment or statewide public measure is to appear on a ballot to be voted upon at a single election, an identifying number shall be assigned by the state commissioner and shall be printed on the ballot in the prescribed manner.

21.200(2) The order of placement on the ballot for each local public measure to be voted upon at a single election shall be determined by the commissioner, and a letter shall be assigned to each local public measure by the commissioner.

a. The letter assigned by the commissioner shall be printed on the ballot at least ⅛ of an inch high in the designated place.

b. Even if only one public measure is to appear on a ballot to be voted upon at a single election, an identifying letter shall be assigned by the commissioner and shall be printed on the ballot in the prescribed manner.

21.200(3) The words describing proposed constitutional amendments and statewide public measures when they appear on the ballot shall be determined by the state commissioner. The state commissioner shall select the words describing the proposed constitutional amendments and statewide public measures in the following manner:

a. Not less than 150 days prior to the election at which a proposed constitutional amendment or statewide public measure is to be voted on by the voters, the state commissioner shall prepare a proposed

description to be used on the ballots in administrative rule form and shall file the proposed rules with the administrative rules coordinator for publication in the Iowa Administrative Bulletin.

b. The rules shall provide that written comments regarding the proposed description will be accepted by the state commissioner for a period of time not less than 20 days after the date of publication in the Iowa Administrative Bulletin.

c. The state commissioner shall review any written comments which have been timely received and make any changes deemed to be warranted in the description to be printed on the ballots.

This rule is intended to implement Iowa Code sections 47.1 and 49.44.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.201(44) Competing nominations by nonparty political organizations.

21.201(1) *Nominations by convention and by petitions.* If one or more nomination petitions are received from nonparty political organization candidates for an office for which the same organization has also nominated one candidate by convention, the candidate nominated by convention shall be considered the nominee of the organization. The names of the other candidates shall appear on the ballot as candidates "nominated by petition," and those candidates shall be notified in writing not later than seven days after the close of the filing period.

21.201(2) *Multiple nomination petitions.* If nomination petitions are received from more than one candidate from the same nonparty political organization for the same office and the organization has not nominated a candidate for the office by convention, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination petition of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

21.201(3) *Multiple nomination certificates.* If more than one nomination certificate is received for the same office from groups with the same nonparty political organization name, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates, including any candidate who filed nomination petitions, shall appear on the ballot as candidates "nominated by petition." A copy of the written record of the result of the drawing shall be kept with the nomination certificate of each affected candidate, and each candidate shall be sent a copy for the candidate's records not later than seven days after the close of the filing period.

This rule is intended to implement Iowa Code section 44.17.

721—21.202(43,52) Form of primary election ballot. All primary election ballots shall meet the following formatting requirements:

21.202(1) *Required information.* In addition to other requirements listed in the Iowa Code, primary election ballots shall also include the following information:

a. The name of the election.

b. The name of the party, which shall be printed at the top of the ballot in at least 24-point type.

c. The name of the county.

d. Instructions for how to mark the ballot.

21.202(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.202(3) *Office titles and order of offices.* Each office printed on the ballot shall be preceded by an office title. The order of offices on the primary election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles on the primary election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) Governor.
(4) Secretary of State.
(5) Auditor of State.
(6) Treasurer of State.
(7) Secretary of Agriculture.
(8) Attorney General.
(9) State Senator, district ___ (if any).
(10) State Representative, District ___.
(11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(12) Treasurer.
(13) Recorder.
(14) County Attorney.

b. In presidential election years, the order of office titles on the primary election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) State Senator, District ___ (if any).
(4) State Representative, District ___.
(5) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(6) Auditor.
(7) Sheriff.

c. If an office is printed on the primary election ballot followed by the words "To Fill Vacancy," that office shall be listed after the other offices under the appropriate heading. If the office followed by the words "To Fill Vacancy" is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.202(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: "Vote for no more than ___." The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election.

21.202(5) *Write-in vote targets.* After the candidates' names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.202(4). Under each write-in line, the following words shall be printed: "Write-in vote, if any."

21.202(6) *Font size.* Candidates' names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.202(7) *Two-sided ballots.* If a primary election ballot must be printed on two sides, the words "Turn the ballot over" shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 43.31 [2009 Iowa Acts, House File 475, section 6].

[**ARC 8698B**, IAB 4/21/10, effective 6/15/10; **ARC 9049B**, IAB 9/8/10, effective 8/16/10]

721—21.203(49,52) Form of general election ballot. All general election ballots shall meet the following formatting requirements:

21.203(1) *Required information.* In addition to other requirements listed in the Iowa Code, general election ballots shall also include the following information:

a. The name of the election.

b. The name of the county.

c. Instructions for how to mark the ballot, including instructions for voting on judicial retentions and constitutional amendments or public measures and instructions for straight-party voting.

d. Ballot location of the judges' names and any constitutional amendment(s).

21.203(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.203(3) *Office titles, order of offices and public measures.* Each office printed on the ballot shall be preceded by an office title. The order of offices and public measures listed on the general election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles and public measures on the general election ballot shall be listed as follows:

(1) U.S. Senator (if any).
(2) U.S. Representative, District ___.
(3) Governor and Lt. Governor.
(4) Secretary of State.
(5) Auditor of State.
(6) Treasurer of State.
(7) Secretary of Agriculture.
(8) Attorney General.
(9) State Senator, District ___ (if any).
(10) State Representative, District ___.
(11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ___).
(12) Treasurer.
(13) Recorder.
(14) County Attorney.
(15) Township Trustee (if any).
(16) Township Clerk (if any).
(17) County Public Hospital Trustee (if any).
(18) Soil and Water Conservation District Commissioner.
(19) County Agricultural Extension Council Member.
(20) Other nonpartisan offices (if any).
(21) Supreme Court Justice (if any).
(22) Court of Appeals Judge (if any).
(23) District Court Judge (if any).
(24) District Court Associate Judge (if any).
(25) Associate Juvenile Judge (if any).
(26) Associate Probate Judge (if any).
(27) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:

1. Constitutional Amendment (if any).
2. State Public Measure (if any).
3. County Public Measure (if any).
4. City Public Measure (if any).

b. In presidential election years, the order of office titles on the general election ballot shall be listed as follows:

(1) President and Vice President.
(2) U.S. Senator (if any).
(3) U.S. Representative, District ___.
(4) State Senator, District ___ (if any).
(5) State Representative, District ___.
(6) Board of Supervisors (if plan II or plan III, then Board of Supervisors, district ___).
(7) Auditor.

(8) Sheriff.
(9) Township Trustee (if any).
(10) Township Clerk (if any).
(11) County Public Hospital Trustee (if any).
(12) Soil and Water Conservation District Commissioner.
(13) County Agricultural Extension Council Member.
(14) Other nonpartisan offices (if any).
(15) Supreme Court Justice (if any).
(16) Court of Appeals Judge (if any).
(17) District Court Judge (if any).
(18) District Court Associate Judge (if any).
(19) Associate Juvenile Judge (if any).
(20) Associate Probate Judge (if any).
(21) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:
1. Constitutional Amendment (if any).
2. State Public Measure (if any).
3. County Public Measure (if any).
4. City Public Measure (if any).

c. If an office is printed on the general election ballot followed by the words "To Fill Vacancy," that office shall be listed after the other offices under the appropriate heading. If the office followed by the words "To Fill Vacancy" is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.203(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: "Vote for no more than ___". The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election. Under the "President and Vice President" office title, "Vote for no more than one team" shall be printed on the ballot. Under the "Governor and Lt. Governor" office title, "Vote for no more than one team" shall be printed on the ballot.

21.203(5) *Write-in vote targets.* After the candidates' names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.203(4). Under each write-in line, the following words shall be printed: "Write-in vote, if any". For the offices of President and Vice President, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: "Write-in vote for President, if any" and "Write-in vote for Vice President, if any". For the offices of governor and lieutenant governor, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: "Write-in vote for Governor, if any" and "Write-in vote for Lt. Governor, if any".

21.203(6) *Font size.* Candidates' names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.203(7) *Two-sided ballots.* If a general election ballot must be printed on two sides, the words "Turn the ballot over" shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 49.57A [2009 Iowa Acts, House File 475, section 32].
[**ARC 8698B**, IAB 4/21/10, effective 6/15/10; **ARC 9049B**, IAB 9/8/10, effective 8/16/10]

721—21.204(260C) Tabulating election results by school district for merged area special elections. All results for merged area special elections, including special precinct results, shall be tabulated by school district. To tabulate the special precinct results in this manner, the county commissioner may either program the voting equipment to tabulate the ballots in this manner or manually sort and tabulate the ballots by school district.

This rule is intended to implement Iowa Code chapter 260C.
[**ARC 9879B**, IAB 11/30/11, effective 1/4/12]

721—21.205 to **21.299** Reserved.

DIVISION III
ABSENTEE VOTING

721—21.300(53) Satellite absentee voting stations.

21.300(1) *Establishment of stations.* Satellite absentee voting stations may be established by the county commissioner of elections or by a petition of eligible electors of the jurisdiction conducting the election.

a. Satellite absentee voting stations established by the county commissioner. The county commissioner of elections may designate locations in the county for satellite absentee voting stations. Satellite absentee voting stations established by the commissioner shall be accessible to elderly and disabled voters. Satellite absentee voting stations must also be established so as to provide for voting in secret and ballot security.

b. Satellite absentee voting stations established after receipt of a valid petition. A petition requesting a satellite absentee voting station shall be substantially in the form titled "Petition Requesting Satellite Absentee Voting Station" available on the state commissioner's Web site. If the commissioner receives a petition requesting a satellite absentee voting station on or before the petition deadline set forth in Iowa Code section 53.11, the commissioner shall determine the validity of the petition within 24 hours. A petition requesting a satellite absentee voting station is valid if it contains signatures of not less than 100 eligible electors of the jurisdiction conducting the election. Electors signing the petition must include their signature, house number, street, and date the petition was signed. Signatures on lines not containing all of the required information shall not be counted. The heading on each page of the petition shall include the satellite location requested and the election name or date for which the location is requested. Signatures on petition pages without the required heading shall not be counted.

c. Mandatory rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations shall be rejected within four days of the commissioner's receipt of the petition if:

(1) The site requested is not accessible to elderly and disabled voters,

(2) The site requested has other physical limitations that make it impossible to meet the requirements for ballot security and secret voting, or

(3) The owner of the site refuses permission to locate the satellite absentee voting station at the site requested on the petition.

d. Discretionary rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations may be rejected within four days of the commissioner's receipt of the petition if:

(1) A petition is received requesting satellite voting for a city runoff election and a special election is scheduled to be held between the regular city election and a city runoff election.

(2) The owner of the site demands payment for its use.

e. Provision of ballots. Only ballots from the county in which the site is located may be provided at the satellite absentee voting station. Ballots must be provided for the precinct in which the satellite absentee voting station is located; however, it is not necessary to provide ballots from all of the precincts in the political subdivision for which the election is being conducted.

21.300(2) *Notice provided.* Notice shall be published at least seven days before the opening of any satellite absentee voting station. If more than one satellite absentee voting station will be provided, a single publication may be used to notify the public of their availability. If it is not possible to publish the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be published as soon as possible.

A notice shall also be posted at each satellite absentee voting station at least seven days before the opening of the satellite absentee voting station. The notice shall remain posted as long as the satellite

absentee voting station is scheduled for service. If it is not possible to post the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be posted as soon as possible.

Both the published and posted notices shall include the following information:

a. The name and date of the election for which ballots will be available.

b. The location(s) of the satellite absentee voting station(s).

c. The dates and times that the station(s) will be open.

d. The precincts for which ballots will be available.

e. An announcement that voter registration forms will be available for new registrations in the county and that changes in the registration records of people who are currently registered within the county may be made at any time.

If the satellite absentee voting station is located in a building with more than one public entrance, brief notices of the location of the satellite absentee voting station shall be posted on building directories, bulletin boards, or doors. These notices shall be posted no later than the time the station opens and shall be removed immediately after the satellite absentee voting station has ceased operation for an election.

21.300(3) *Staff.* Satellite absentee voting station workers may be selected from among the staff members of the commissioner's office, from the election board panel drawn up pursuant to Iowa Code sections 49.15 and 49.16, or a combination of these two sources. Compensation of workers selected from the election board panel shall be at the rate provided in Iowa Code section 49.20.

At least three people shall be assigned to work at each satellite absentee voting station; more workers may be added at the commissioner's discretion. All workers must be registered voters of the county, and for primary and general elections the workers must be registered with a political party; however, workers not affiliated with any party may be assigned to work at a satellite absentee voting station as long as not more than one-third of the workers assigned to a particular satellite absentee voting station are not affiliated with a political party. For all elections, no more than a simple majority of the workers shall be members of the same political party.

People who are prohibited from working at the polls pursuant to Iowa Code section 49.16 may not work at satellite absentee voting stations.

21.300(4) *Oath required.* Before the first day of service at a satellite absentee voting station, each worker shall take an oath substantially in the form titled "Election Official/Clerk Oath" available on the state commissioner's Web site. The oath must be taken before each election.

21.300(5) *Suggested supplies for each satellite absentee voting station.* A list of supplies suggested for each satellite absentee voting station is available on the state commissioner's Web site.

21.300(6) *Ballot transport and storage.* At the commissioner's discretion the ballots may be transported between the commissioner's office and the satellite absentee voting station by the workers who will be on duty that day, or by two people of different political parties who have been designated as couriers by the commissioner. It is not necessary for the same people to transport the ballots in both directions.

If the ballots are transported by the satellite absentee voting station workers, two workers who are members of different political parties and the ballots must travel together in the same vehicle.

Ballots may be stored at the satellite absentee voting station during hours when the station is closed only if they are kept in a locked cabinet or container. The cabinet must be located in a room which is kept locked when not in use. Voted absentee ballots must be delivered to the commissioner's office at least once each week.

21.300(7) *Ballot receipts.* Satellite absentee voting station workers shall sign receipts for the ballots taken to the satellite absentee voting site. The receipt shall be substantially in the form titled "Satellite Absentee Voting Station Ballot Record and Receipt" available on the state commissioner's Web site. A copy of the ballot record and receipt shall be retained in the commissioner's office. The original shall be sent with the ballots to the satellite absentee voting station.

21.300(8) *Arrangement of the satellite absentee voting station.* Protection of the security of the ballots (both voted and unvoted) and the secrecy of each person's vote shall be considered in the arranging of the satellite absentee voting station.

a. Security. The satellite absentee voting station shall be arranged so that ballots are protected against removal from the station by unauthorized persons.

b. Voting area. Voting booths without curtains shall be placed so that passersby and other voters may not walk directly behind a person using the booth. At least one voting booth must be accessible to the disabled. The booth must be designed to accommodate a person seated in a chair or wheelchair. A chair must be provided for voters who wish to sit down while voting or waiting in line.

c. Campaign signs and electioneering. No signs supporting or opposing any candidate or question on the ballot shall be posted on the premises of or within 300 feet of any outside door of any building affording access to a satellite absentee voting station during the hours when absentee ballots are available at the satellite absentee voting station. No electioneering shall be allowed within the sight or hearing of voters while they are at the satellite absentee voting station.

21.300(9) *Operation of the satellite absentee voting station.* At all times the satellite absentee voting station shall have at least two workers present to preserve the security of the ballots, both voted and unvoted.

21.300(10) *Voter registration at the satellite absentee voting station.* Each satellite absentee voting station shall provide forms necessary to register voters, including the oaths necessary to process voters registering pursuant to Iowa Code section 48A.7A, and to record changes in voter registration records. Workers shall also be provided with a method of verifying whether people applying for absentee ballots are registered voters.

The commissioner may provide a list of registered voters in the precincts served by the station. The list may be on paper or contained in a computerized data file. As an alternative, the commissioner may provide a computer connection with the commissioner's office.

21.300(11) *Procedure for issuing absentee ballot.* The instructions for absentee voting are available on the state commissioner's Web site and shall be provided to satellite absentee voting station workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner's Web site.

21.300(12) *Closing a station.* The instructions for closing a satellite absentee voting station are available on the state commissioner's Web site and shall be provided to satellite absentee voting station workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner's Web site.

21.300(13) *Use of I-Voters at satellite absentee voting stations.* Any county commissioner who wants to use the I-Voters statewide voter registration database at a satellite absentee voting station shall:

a. Complete an application to use I-Voters at a satellite absentee voting station. A separate application shall be completed for each satellite absentee voting station. The application is available on the state commissioner's Web site. The application shall be submitted at least seven days before the opening of the satellite absentee voting station. If it is not possible to submit an application at least seven days before the station opens due to the receipt of a petition, the application shall be submitted as soon as possible. The application will be considered by the state commissioner as soon as practicable after it is received. The state commissioner reserves the right to reject an application for any reason or to limit the number of users at any satellite absentee voting station.

b. Use a cellular telephone service or a wired Internet connection to connect to the Internet from the satellite absentee voting station. If the county uses a wired Internet connection, the commissioner shall use either a regular or a wireless router between the wired Internet connection and the county's computers. Connection to a facility's wireless network is not permitted.

c. Configure any wireless routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

(1) A minimum 10-character password must be assigned to the router administration screens.

(2) WPA (AES) security for wireless connections with a minimum 10-character password must be used.

(3) Remote management of the router must be prohibited.

(4) Universal Plug & Play must be turned off.

(5) Port forwarding on the router must not be disabled.

(6) Unauthorized connections shall be prohibited, including smartphones, personal digital assistants (PDAs) and laptops.

d. Configure any wired routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

(1) Remote management of the router must be prohibited.

(2) Universal Plug & Play must be turned off.

(3) Port forwarding on the router must not be disabled.

(4) Unauthorized connections shall be prohibited, including smartphones, PDAs and laptops.

(5) Administrator passwords for the routers must be changed from the default passwords, and standard county password policies shall be followed.

e. Laptops used at a satellite absentee voting station shall be configured as follows:

(1) The hard drives must be encrypted.

(2) The operating system must be fully supported by the operating system vendor.

(3) The operating system must be fully patched.

(4) Antivirus software and anti-spyware must be installed and up to date.

(5) A full antivirus and anti-spyware scan must be done during the week before a laptop is used at a satellite absentee voting station and at least once a week thereafter while the laptop is being used at satellite absentee voting stations.

(6) The administrator password must be changed from the default password.

(7) Guest user accounts must be disabled or renamed.

(8) File/print sharing must be turned off, and remote access must be disabled.

(9) Bluetooth must be turned off.

(10) The Windows firewall must be turned on.

f. Laptops connected to I-Voters at a satellite absentee voting station shall never be left unattended.

g. Laptops connected to I-Voters at a satellite absentee voting station shall not have any USB memory sticks or CDs/DVDs inserted in the computer after the virus scan is conducted pursuant to subrule 21.300(13), paragraph *"e."*

h. Laptops connected to I-Voters at a satellite absentee voting station shall not be used to visit any other Web sites.

i. No software applications, other than I-Voters, shall be used while the I-Voters application is in use at a satellite absentee voting station.

21.300(14) *Provisional voting at satellite absentee voting stations.* If it is necessary for a voter to cast a provisional ballot at a satellite absentee voting station, the voter shall receive the same ballot style as the majority of the voters would receive in the precinct in which the satellite absentee voting station is located.

This rule is intended to implement Iowa Code section 53.11.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9139B**, IAB 10/6/10, effective 9/16/10; **ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—21.301(53) Absentee ballot requests from voters whose registration records are "inactive."

21.301(1) *In person.* Absentee voters whose registration records are "inactive" and who appear in person to vote, either at the office of the commissioner or at a satellite absentee voting station, shall be assigned a status of "active" after requesting an absentee ballot.

21.301(2) *By mail.* When a request for an absentee ballot is received by mail from a voter whose registration record has been made "inactive" pursuant to Iowa Code section 48A.29, the commissioner shall update the voter's residential address to the address listed on the absentee ballot request if requested by the voter and assign the voter a status of "active."

21.301(3) *Absentee ballots received from a voter subsequently assigned "inactive" status.*

a. The commissioner shall mail an absentee ballot to a voter if a voter's status is changed to "inactive" between the time the voter requested an absentee ballot and the time the absentee ballots are ready to mail. The commissioner shall also separately notify the voter of the requirement to provide identification before the ballot can be counted pursuant to paragraph 21.301(3)*"c."*

b. The commissioner shall set aside the absentee ballot of a voter whose status is changed to "inactive" pursuant to Iowa Code section 48A.26, subsection 6, after the voter has submitted the voter's absentee ballot.

c. Pursuant to Iowa Code section 53.31, the commissioner shall notify any voter assigned an "inactive" status subsequent to requesting or returning an absentee ballot that the voter's absentee ballot has been challenged and may be counted only if the voter personally delivers or mails a copy of the voter's identification as listed in Iowa Code section 48A.8 to the commissioner's office before the absentee and special voters precinct board convenes to count absentee ballots, or reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22. If the commissioner does not receive a copy of the voter's identification before the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the absentee and special voters precinct board shall reject the absentee ballot.

This rule is intended to implement Iowa Code section 48A.29 and sections 48A.26, 48A.37 and 53.25 as amended by 2009 Iowa Acts, House File 475.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—21.302(48A) In-person absentee registration. After the close of voter registration for an election, a person who appears in person to apply for and vote an absentee ballot may register to vote if the person provides proof of identity and residence in the precinct in which the voter intends to vote using identification that meets the requirements set forth in Iowa Code section 48A.7A. The voter must also complete an oath of person registering on election day. If the voter does not have appropriate identification, the voter may establish identity and residence using the attestation procedure in Iowa Code section 48A.7A, subsection 1, paragraph *"c."* Otherwise, the person may cast only a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballot envelopes shall be used.

This rule is intended to implement Iowa Code section 48A.7A.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.303(53) Mailing absentee ballots. The commissioner shall mail the following materials to each person who has requested an absentee ballot:

1. Ballot. The ballot that corresponds to the voter's residence, as indicated by the address on the absentee ballot application.
2. Public measure text. The full text of any public measures that are summarized on the ballot, but not printed in full.
3. Secrecy envelope. Secrecy envelope, if the ballot cannot be folded to cover all of the voting ovals, as required by Iowa Code section 53.8(1).
4. Affidavit envelope. The affidavit envelope, which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.
5. Return carrier envelope. The return carrier envelope, which shall be addressed to the commissioner's office and bear appropriate return postage or a postal permit guaranteeing that the commissioner will pay the return postage and which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.
6. Delivery envelope. The delivery envelope, which shall be addressed to the voter and bear the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records. All other materials shall be enclosed in the delivery envelope.
7. Instructions. Absentee voting instructions, which shall be in substantially the form prescribed by the state commissioner of elections.
8. Receipt. The receipt form required by 2007 Iowa Acts, Senate File 601, section 227, which may be printed on the instructions required by numbered paragraph "7" above.

This rule is intended to implement Iowa Code sections 53.8 and 53.17 as amended by 2009 Iowa Acts, House File 475.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.304(53) Absentee ballot requests from voters whose registration records are "pending." A voter who requests an absentee ballot and is assigned a status of "pending" must provide identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475.

21.304(1) *In-person applicants.* In-person applicants for absentee ballots assigned a status of "pending" must show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, before casting a ballot. If an in-person applicant provides identification as required by Iowa Code section 48A.8 when casting an absentee ballot in person, the commissioner shall assign the voter's registration record a status of "active" and provide the voter with an absentee ballot. Voters who are unable to provide identification as required by Iowa Code section 48A.8 shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

21.304(2) *By-mail applicants.* By-mail applicants for absentee ballots assigned a status of "pending" must either come to the commissioner's office and show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, or mail a photocopy of identification pursuant to Iowa Code section 48A.8 before the voter's absentee ballot can be counted by the absentee and special voters precinct board. The commissioner shall mail the voter a notice informing the voter of the requirement to provide one of the identification documents listed in Iowa Code section 48A.8 before the voter's absentee ballot can be considered for counting by the absentee and special voters precinct board. If a by-mail applicant provides identification as required by Iowa Code section 48A.8, the commissioner shall assign the voter's registration record a status of "active."

21.304(3) *By-mail absentee voters assigned a status of "pending" who do not provide identification prior to election day.* The ballot of a by-mail absentee voter assigned a status of "pending" who has not shown identification in person at the commissioner's office or provided a photocopy of identification by mail pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, shall be challenged by a member of the absentee and special voters precinct board on election day pursuant to Iowa Code section 53.31. The absentee and special voters precinct board shall immediately mail notice of the challenge to the voter. The notice shall include the deadline for the voter to provide identification pursuant to Iowa Code section 48A.8. If the voter provides identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's ballot shall be considered for counting by the absentee and special voters precinct board. If the voter does not provide identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's absentee ballot shall be rejected by the absentee and special voters precinct board. The voter shall be notified of the reason for rejection pursuant to Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475.

This rule is intended to implement Iowa Code section 53.31 and sections 48A.8 and 53.25 as amended by 2009 Iowa Acts, House File 475.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.305(53) Confirming commissioner's receipt of an absentee ballot on election day. If a voter's name is on the absentee list prepared pursuant to Iowa Code sections 49.72 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196, and the voter appears at the polling place to vote on election day, the precinct election officials may contact the commissioner's office to confirm whether the commissioner has received the voter's absentee ballot. If the precinct election officials are able to confirm either that the commissioner has not received the voter's absentee ballot or that the voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the precinct election officials shall permit the voter to cast a regular ballot at the polling place.

After confirming that a voter's absentee ballot has not been received or that a voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the commissioner shall mark the voter's absentee ballot as "Void" in the statewide voter registration system. The commissioner shall enter "Voted at polls" in the comment box that appears when the ballot is marked as "Void."

If a voter's absentee ballot is returned to the commissioner's office after being marked as "Void" pursuant to this rule, the absentee ballot shall be rejected by the absentee and special voters precinct board pursuant to Iowa Code section 53.25 because the voter cast a ballot in person at the polling place.

This rule is intended to implement Iowa Code sections 49.72, 49.81 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196.

[**ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.306 to **21.319** Reserved.

721—21.320(53) Absentee voting by UOCAVA voters. This rule applies only to absentee voting by persons who are entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(1) *Definitions.* The following definitions apply to this rule:

"Armed forces," as used in this rule, is defined in Iowa Code section 53.37(3).

"FPCA" means the federal postcard absentee ballot application and voter registration form authorized for use in Iowa by Iowa Code section 53.38.

"UOCAVA voter" means any person who is entitled to vote by absentee ballot under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(2) *Requests for absentee ballots.* All requests for absentee ballots shall be made in writing. Additional requirements for requesting absentee ballots and for processing the requests are set forth below.

a. Forms. UOCAVA voters may use the following official forms to request absentee ballots:

(1) A federal postcard absentee ballot application and voter registration form (FPCA).

(2) A state of Iowa official absentee ballot request form.

(3) For general elections only, a proxy absentee ballot application prescribed by the state commissioner of elections and submitted pursuant to Iowa Code Supplement section 53.40(1)*"b."*

b. Form not required. UOCAVA voters may request absentee ballots in writing without using an official form. The written request shall be honored if it includes all of the following information about the voter:

(1) Name.

(2) Age or date of birth.

(3) Iowa residence, including street address (if any) and city.

(4) Address to which the ballot shall be sent.

(5) Township of residence, if applicable.

(6) County of residence.

(7) Party affiliation, if the request is for a ballot for a primary election.

(8) Signature of voter.

(9) Statement explaining why the voter is eligible to receive ballots under the provisions of Iowa Code chapter 53, division II. For example, "I am a U.S. citizen living in France."

c. Methods for transmitting absentee ballot requests. UOCAVA voters may transmit absentee ballot requests by any of the following methods:

(1) Mail.

(2) Personal delivery by the voter or a person designated by the voter.

(3) Facsimile machine.

(4) Scanned application form or letter transmitted by E-mail. Requests by E-mail that do not include either an image of the physical signature or a digital signature shall not be accepted.

d. Original request not needed. If the request is sent by E-mail or by fax, it is not necessary for the UOCAVA voter to send to the commissioner the original copy of the FPCA or other official form or written request for an absentee ballot.

e. Multiple requests from the same person. Before the ballot is ready to mail, if the commissioner receives more than one request for an absentee ballot for a particular election (or series of elections) by or on behalf of a UOCAVA voter, the last request received shall be the one honored. However, if one of the requests is for a general election ballot and is made using the proxy absentee ballot application process permitted by Iowa Code Supplement section 53.40(1)*"b,"* the request received from the voter shall be the one honored, not the proxy request.

f. Subsequent request after ballot has been sent. Not more than one ballot shall be transmitted by the commissioner to any UOCAVA voter for a particular election unless, after the ballot has been mailed or transmitted electronically pursuant to rule 721—21.320(53), the voter reports a change in the address, E-mail address or fax number to which the ballot should be sent. The commissioner shall void the original absentee ballot request and include a comment in the voter's registration record, noting the I-Voters-sequence number of the original ballot and noting that a replacement ballot was sent to an updated address. If the original ballot is returned voted, it shall be counted only if the replacement ballot does not arrive before the deadline for receiving absentee ballots set forth in Iowa Code section 53.17.

g. Requests for absentee ballots through the end of the calendar year. 2009 Iowa Code Supplement section 53.40 as amended by 2010 Iowa Acts, Senate File 2194, permits UOCAVA voters to request the commissioner to send absentee ballots for all elections as permitted by state law. In response to an absentee ballot request in which the UOCAVA voter requests ballots for all elections, the commissioner shall send the applicant a ballot for each election held after the request is received through the end of the calendar year in which the request is received. If the applicant does not request ballots for all elections or does not specify which elections the request is for, the commissioner shall send the applicant a ballot only for federal elections through the end of the calendar year in which the request is received.

(1) When an absentee ballot for a UOCAVA voter is returned as undeliverable by the United States Postal Service or an E-mail server or a fax cannot be transmitted to the number provided by the voter, the commissioner shall do the following:

1. Verify that the commissioner's office sent the absentee ballot to the address, E-mail address or fax number requested by the UOCAVA voter. If the absentee ballot was sent incorrectly, the commissioner shall correct the error and immediately transmit a new absentee ballot.

2. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall E-mail the voter if the commissioner has an E-mail address on file to inform the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address if the voter wishes to continue to receive absentee ballots.

3. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall also attempt to contact the voter by sending a forwardable notice to both the voter's residential address and the voter's absentee mailing address informing the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address, E-mail address or fax number if the voter wishes to continue to receive absentee ballots.

4. If the absentee ballot was mailed, E-mailed or sent to the correct address or fax number, the commissioner shall terminate the voter's current FPCA request and shall not send the voter any further ballots unless a new absentee ballot request is received from the voter.

(2) If the voter provides a new FPCA with a new mailing address, E-mail address or fax number before election day, the commissioner shall enter a new absentee request on the voter's registration record and transmit the ballot via the method requested by the voter. The voter may request that the commissioner transmit the ballot electronically pursuant to subrule 21.320(3).

21.320(3) *Electronic transmission of absentee ballots to UOCAVA voters.*

a. Electronic transmission of absentee ballots by facsimile machine or by E-mail is limited to UOCAVA voters who specifically ask for this service. A UOCAVA voter who asks for electronic transmission of an absentee ballot may request this service for all elections for which the person is qualified to vote or for specific elections either individually or for a specific period of time. The commissioner may employ FVAP's secure transmission program to facilitate electronic transmission of absentee ballots to UOCAVA voters.

b. Forms. The state commissioner shall provide the following forms and instructions for the electronic transmission of absentee ballots to UOCAVA voters:

(1) Instructions to the county commissioners of elections for providing this service.

(2) Instructions to the voter for marking and returning the ballot.

(3) The affidavit envelope form, which can be printed by the voter on an envelope and used for the voter's declaration of eligibility and voter registration application, if necessary.

(4) The return envelope form, which can be printed by the voter on an envelope and used to return the ballot, postage paid through the FPO/APO postal service.

21.320(4) *Ballot return by electronic transmission.*

a. Electronic transmission of a voted absentee ballot from the voter to the commissioner is permitted only for UOCAVA voters who are located in an area designated as an imminent danger pay area or for active members of the army, navy, marine corps, merchant marine, coast guard, air force or Iowa national guard who are located outside the United States or any of its territories, as provided in subrule 21.1(13). In addition, the absentee ballot may be returned via electronic transmission only if the voter waives the right to a secret ballot. In addition to signing the affidavit required by Iowa Code section 53.13, the voter shall sign a statement in substantially the following form: "I understand that by returning this ballot by electronic transmission, my voted ballot will not be secret. I hereby waive my right to a secret ballot."

b. When an absentee ballot is received via electronic transmission, the person receiving the transmission shall examine it to determine that all pages have been received and are legible. The person receiving an electronic transmission shall not reveal how the voter voted.

c. The absentee ballot shall be sealed in an envelope marked with the voter's name. The affidavit of the voter and the application for the ballot shall be attached to the envelope. These materials shall be stored with other returned absentee ballots.

This rule is intended to implement Iowa Code sections 53.40 and 53.46.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8777B**, IAB 6/2/10, effective 5/7/10; **ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—21.321 to **21.349** Reserved.

721—21.350(53) Absentee ballot processing for elections held following July 1, 2007. Rescinded IAB 9/26/07, effective 9/7/07.

721—21.351(53) Receiving absentee ballots. The commissioner shall carefully account for and protect all absentee ballots returned to the office.

21.351(1) *Note receipt.* The commissioner shall write or file-stamp on the return carrier envelope the date that the ballot arrived in the commissioner's office. The commissioner shall also record receipt of the ballot in I-Voters.

21.351(2) *Temporary storage.* If necessary, the commissioner shall immediately put the ballot into a secure container, such as a locked ballot box, until the ballots can be moved to the secure storage area.

21.351(3) *Secure area.* The commissioner shall deliver the ballots to a secure area where returned absentee ballots will be reviewed for completeness and defects.

[**ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.352(53) Review of returned affidavit envelopes.

21.352(1) *Personnel.* The commissioner may assign staff members to complete the review of returned affidavit envelopes. Only persons who have been trained for this responsibility shall be authorized to review affidavit envelopes.

21.352(2) *Affidavit envelopes reviewed.* The affidavit envelopes of all absentee ballots returned to the commissioner's office shall be reviewed, including those of ballots returned by the bipartisan team delivering absentee ballots to health care facilities, such as hospitals and nursing homes. If a reviewer finds that any absentee affidavits returned from any health care facility are incomplete or defective, the commissioner shall send the bipartisan delivery team back to assist voters as needed with completing affidavits or to deliver any replacement ballots.

21.352(3) *Instructions.* Each reviewer shall receive instructions in substantially the form prepared by the state commissioner of elections. The instructions shall provide basic security and procedural guidance and include a method for accounting for all returned absentee ballots. The prohibitions shall include:

a. Leaving unsecured ballots unattended.

b. Altering any information on any affidavit.

c. Adding any information to any affidavit, except as specifically required to comply with the requirements of the law.

d. Sealing any affidavit envelope found open.

e. Discarding any return carrier envelopes, ballots, or affidavit envelopes returned by voters.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.353(53) Opening the return carrier envelopes. The commissioner may direct a staff member to open the return carrier envelopes either manually or with an automatic letter opener, if one is available. Only a trained reviewer may remove the contents of the envelope.

721—21.354(53) Review process. A reviewer shall remove the contents from only one return carrier envelope at a time.

21.354(1) *Return carrier envelopes preserved.* The return carrier envelopes shall be stored in a manner that will facilitate their retrieval, if necessary. They shall be stored for 22 months for federal elections and 6 months for local elections.

21.354(2) *Examination of affidavit envelope.* The reviewer shall make sure that:

a. The affidavit envelope is sealed, apparently with the ballot inside.

b. The affidavit envelope has not been opened and resealed.

c. The affidavit includes all of the following:

(1) A signature.

(2) For primary elections only, political party affiliation.

21.354(3) *No defects or incomplete information.* If the reviewer finds that the required information on the affidavit is complete and that there are no defects that would cause the absentee and special voters precinct board to reject the ballot, the reviewer shall put the affidavit envelope into a group of envelopes to be retained in the secure storage area with others that require no further attention until they are delivered to the absentee and special voters precinct board.

21.354(4) *Defective and incomplete affidavits.* The commissioner shall contact the voter if the reviewer finds any of the following flaws in the affidavit or affidavit envelope:

a. The commissioner shall contact the voter immediately if the affidavit envelope is defective. An affidavit envelope is defective if:

(1) The absentee ballot is not enclosed in the affidavit envelope.

(2) The affidavit envelope is not sealed.

(3) The affidavit envelope has been opened and resealed.

(4) The voter submits a change of address in a new precinct after returning a voted absentee ballot.

b. The commissioner shall contact the voter within 24 hours if the affidavit is incomplete. An incomplete affidavit lacks:

(1) The signature of the voter.

(2) For primary elections only, political party affiliation.

c. If an affidavit envelope has flaws that are included in both paragraphs *"a"* and *"b,"* the commissioner shall follow the process in paragraph *"a."*

21.354(5) *Defective and incomplete affidavits stored separately.* The commissioner shall store the defective and incomplete affidavit envelopes separately from other returned absentee ballot affidavit envelopes.

a. Incomplete affidavit envelopes requiring voter correction must be available for retrieval when the voter comes to make corrections.

b. Defective affidavit envelopes must be attached to the replacement ballot (if any) for review by the absentee and special voters precinct board.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.355(53) Notice to voter. When the commissioner finds an incomplete absentee ballot affidavit or finds a defective affidavit envelope, the commissioner shall notify the voter in writing and, if possible, by telephone and by E-mail. The commissioner shall keep a separate checklist for each voter showing the reasons for which the voter was contacted and the methods used to contact the voter.

21.355(1) *Notice to voter—incomplete ballot affidavit.* Within 24 hours after receipt of an absentee ballot with an incomplete affidavit, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include:

a. Explanation of missing required information (lack of signature or, for primary elections only, political party affiliation).

b. The voter's options for correcting the affidavit as follows:

(1) Completing the affidavit at the commissioner's office by 5 p.m. the day before the election;

(2) Requesting a replacement ballot pursuant to Iowa Code section 53.18; or

(3) Voting at the polls on election day.

c. Address of commissioner's office, business hours and contact information.

21.355(2) *Notice to voter—defective ballot affidavit.* Immediately after determining that an absentee ballot affidavit envelope is defective, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include the following information:

a. Reason for defect.

b. The voter's options for correcting the defect as follows:

(1) The voter may request a replacement ballot;

(2) The voter may vote at the polls on election day; or

(3) In the event an absentee ballot becomes defective because a voter reregisters to vote in a new precinct or county after casting an absentee ballot, the voter may correct the defect by reregistering to vote in the precinct in which the absentee ballot was cast, provided the voter can still claim residence for voter registration purposes in the precinct in which the absentee ballot was cast pursuant to Iowa Code sections 48A.5 and 48A.5A. If a voter reregisters after the voter registration deadline listed in Iowa Code section 48A.9 for a particular election, the voter shall be required to follow election day registration procedures as set forth in Iowa Code section 48A.7A, subsection 3.

c. Process for requesting a replacement ballot.

d. Address of commissioner's office, business hours and contact information.

21.355(3) *Telephone contact.* If the voter has provided a telephone number, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by telephone. The commissioner shall keep a written record of the telephone conversation. The written record shall include the following information:

a. Name of the person making the call.

b. Date and time of the call.

c. Whether the person making the call spoke to the voter.

21.355(4) *E-mail contact.* If the voter has provided an E-mail address, either on the absentee ballot application or on the voter's registration record, the commissioner shall also attempt to contact the voter by E-mail. The E-mail message shall be the same message that was mailed to the voter. A copy of the E-mail message shall be attached to the checklist.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10; **ARC 9989B**, IAB 2/8/12, effective 1/17/12]

Rules 721—21.351(53) through 721—21.355(53) are intended to implement 2009 Iowa Code Supplement section 53.18 as amended by 2010 Iowa Acts, Senate file 2196, and section 53.25.

721—21.356 to **21.358** Reserved.

721—21.359(53) Processing absentee ballots before election day. The commissioner may only direct the absentee and special voters precinct board to open affidavit envelopes on the Monday before election day under the following circumstances:

For any election, only if the commissioner has provided secrecy envelopes (or folders) pursuant to subrule 21.359(1) and the commissioner determines removing secrecy envelopes from affidavit envelopes is necessary due to the quantity of voted absentee ballots received as set forth in Iowa Code section 53.23, subsection 3, paragraph *"a."*

For general elections, if the commissioner convenes the absentee and special voters precinct board pursuant to Iowa Code section 53.23, subsection 3, paragraph *"c,"* to begin tabulation of absentee ballots.

21.359(1) The secrecy envelope shall completely cover the ballot. The envelope shall have the following message printed on it using at least 24-point type:

Secrecy Envelope

After you vote, put your ballot in here.

21.359(2) When the absentee and special voters precinct board convenes to begin processing absentee ballots, the board shall first review voters' affidavits to determine which ballots will be accepted for counting and prepare the notices to those voters whose ballots have been rejected for the reasons set forth in 2009 Iowa Code Supplement section 53.25. Affidavit envelopes containing ballots that are rejected shall be stored in the manner prescribed by Iowa Code section 53.26. The applications submitted for rejected ballots shall be stored in a secure location for the time period required by Iowa Code section 50.19.

21.359(3) The affidavit envelopes containing ballots that have been accepted for counting by the absentee and special voters precinct board shall be stacked with the affidavits facing down. The envelopes shall be opened and the secrecy envelope containing the ballot shall be removed.

21.359(4) If a voter has not enclosed the ballot in a secrecy envelope and the ballot has not been folded in a manner that conceals all votes marked on the ballot, the officials shall put the ballot in a secrecy envelope without examining the ballot.

21.359(5) The following security procedures shall be followed:

a. The process shall be witnessed by observers appointed by the county chairperson of each of the political parties referred to in Iowa Code section 49.13, subsection 2. If, after receiving notice from the commissioner pursuant to Iowa Code section 53.23, subsection 3, paragraph *"a,"* either or both political parties fail to appoint an observer, the commissioner may continue with the proceedings.

b. No ballots shall be counted or examined before election day except as provided in Iowa Code section 53.23, subsection 3, paragraph *"c,"* as amended by 2009 Iowa Acts, House File 670, section 1.

c. When secrecy envelopes are removed from affidavit envelopes on the day before an election and not tabulated as permitted by Iowa Code section 53.23, subsection 3, paragraph *"c,"* as amended by 2009 Iowa Acts, House File 670, section 1, the number of secrecy envelopes shall be recorded before the ballots are stored and the number shall be verified before any ballots are removed from the secrecy envelopes on election day. The ballots may be bundled and sealed in groups of a specified number to make counting easier.

This rule is intended to implement Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.360(53) Failure to affix postmark date. Rescinded IAB 4/20/11, effective 3/31/11.

721—21.361(53) Rejection of absentee ballot. The absentee and special voters precinct board shall reject absentee ballots without opening the affidavit envelope if any of the conditions cited in Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475, exist.

21.361(1) An absentee ballot shall be rejected if the affidavit lacks the voter's signature.

21.361(2) An absentee ballot shall be rejected if the applicant is not a duly registered voter in the precinct in which the ballot is cast. "Precinct" means a precinct established pursuant to Iowa Code sections 49.3 through 49.5 or a consolidated precinct established by the commissioner pursuant to Iowa Code section 49.11, subsection 3, paragraph *"a."*

21.361(3) An absentee ballot shall be rejected if the affidavit envelope is open.

21.361(4) An absentee ballot shall be rejected if the affidavit envelope has been opened and resealed.

21.361(5) An absentee ballot shall be rejected if the affidavit envelope contains more than one ballot of any kind.

21.361(6) An absentee ballot shall be rejected if the voter has voted in person at the polls.

21.361(7) An absentee ballot shall be rejected if in primary elections the voter does not declare a party affiliation on the voter's affidavit.

This rule is intended to implement Iowa Code sections 49.9 and 53.14 and section 53.25 as amended by 2009 Iowa Acts, House File 475.
[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.362 to **21.369** Reserved.

721—21.370(53) Training for absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.371(53) Certificate. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.372(53) Frequency of training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.373(53) Registration of absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.374(53) County commissioner's duties. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.375(53) Absentee ballot courier training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.376(53) Receiving absentee ballots. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.377 to **21.399** Reserved.

DIVISION IV
INSTRUCTIONS FOR SPECIFIC ELECTIONS

721—21.400(376) Signature requirements for certain cities. This rule applies to cities which have all of the following characteristics:

1. Nomination procedures under Iowa Code section 376.3 are used. (This includes cities with primary or runoff election provisions. It does not include cities with nominations under Iowa Code chapter 44 or 45.)
2. Some or all council members are voted upon by the electors of wards, rather than by the electors of the entire city.
3. Ward boundaries have been changed since the last regular city election at which the ward seat was on the ballot.
4. The number of wards has not changed.

Calculation of the number of signatures for ward seats shall use the vote totals from the wards as the wards were configured at the time of the last regular city election at which the ward seat was on the ballot.

This rule is intended to implement Iowa Code section 376.4.

721—21.401(376) Signature requirements in cities with primary or runoff election provisions. In cities using the provisions of Iowa Code section 376.4 for nomination of candidates and in which more

than one council member was elected at-large at the last preceding regular city election, the number of signatures shall be calculated by the following formula:

V = the total number of votes cast for all candidates for council member at-large at the last regular city election;

E = the number of people to be elected at the last regular city election;

$$\frac{V}{E} \times .02 = \text{the number of signatures needed by each candidate in the next regular city election.}$$

This rule is intended to implement Iowa Code section 376.4.

721—21.402(372) Filing deadline for charter commission appointment petition. If a special election has been called by a city to present to the voters the question of adopting a different form of city government, receipt by the city council of a petition requesting appointment of a charter commission shall stay the special election if the petition is received no later than 5 p.m. on the Friday preceding the date of the special election.

This rule is intended to implement Iowa Code section 372.3.

721—21.403(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities that may be required to conduct primary elections.

21.403(1) *Notice to the commissioner.* At least 60 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election.

a. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

b. No special city elections to fill vacancies for cities that may be required to conduct primary elections shall be held with the general election, with the primary election, or with the annual school election. To do so would be contrary to the provisions of Iowa Code section 39.2.

21.403(2) *Election calendar.* The election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the fifty-third day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the fifty-third day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the fiftieth day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the fiftieth day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.404(81GA,HF2282) Special elections to fill vacancies in elective city offices for cities without primary election requirements. This rule applies to cities that have adopted by ordinance one of the following options: nominations under Iowa Code chapter 44 or chapter 45, or a runoff election requirement if no candidate in the special election receives a majority of the votes cast.

21.404(1) *Notice to the commissioner.* At least 32 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

21.404(2) *Special elections to fill vacancies held in conjunction with the general election.* If the proposed date of the special election coincides with the date of the general election, the council shall give notice of the proposed date of the special city election not later than 76 days before the date of the general election. Candidates shall file nomination papers with the city clerk not later than 5 p.m. on the seventieth day before the general election. The city clerk shall deliver the nomination papers accepted by the clerk not later than 5 p.m. on the sixty-ninth day before the general election. Objection and withdrawal deadlines shall be 64 days before the general election, the same as the deadlines for candidates who file their nomination papers with the commissioner. Hearings on objections shall be held as soon as possible in order to facilitate printing of the general election ballot.

21.404(3) *Election calendar.* If the special election date is not the same as the date of the general election, the election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the twenty-fifth day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the twenty-fifth day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the twenty-second day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the twenty-second day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.405 to **21.499** Reserved.

721—21.500(277) Signature requirements for school director candidates. The number of signatures required to be filed by candidates for the office of director in the regular school election shall be calculated from the number of registered voters in the district on May 1 of the year in which the election will be held. If May 1 falls on a day when the commissioner's office is closed for business, the commissioner shall use the number of registered voters in the district on the next day that the commissioner's office is open for business to determine the number of required signatures. Candidates who are seeking election in districts with election plans as specified in Iowa Code section 275.12(2)*"b"* and *"c,"* where the candidate must reside in a specific director district, but is voted upon by all of the electors of the school district, shall be required to file a number of signatures calculated from the number of registered voters in the whole school district. Candidates who will be voted upon only by the electors of a director district shall be required to file a number of signatures calculated from the number of registered voters in the director district in which the candidate resides and seeks to represent.

If a special election is to be held to fill a vacancy on the school board, the number of registered voters on the date the commissioner receives notice of the special election shall be used to calculate the number of signatures required for the special election.

This rule is intended to implement Iowa Code sections 277.4 and 279.7.

[**ARC 9466B**, IAB 4/20/11, effective 3/31/11]

721—21.501 to **21.599** Reserved.

721—21.600(43) Primary election signatures—plan three supervisor candidates. Rescinded IAB 11/30/11, effective 1/4/12.

721—21.601(43) Plan III supervisor district candidate signatures after a change in the number of supervisors or method of election. After the number of supervisors has been increased or decreased pursuant to Iowa Code section 331.203 or 331.204 or the method of electing supervisors has been

changed from plan I or plan II to plan III since the last general election, the signatures for candidates at the next primary and general elections shall be calculated as follows:

21.601(1) *Primary election.* Divide the total number of party votes cast in the county at the previous general election for the office of president or for governor, as applicable, by the number of supervisor districts and multiply the quotient by .02. If the result of the calculation is less than 100, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 100, the minimum requirement shall be 100 signatures.

21.601(2) *Nominations by petition.* If the effective date of the change in the number of districts or method of election was later than the date specified in Iowa Code section 45.1(6), divide the total number of registered voters in the county on the date specified in Iowa Code section 45.1(6) by the number of supervisor districts and multiply the quotient by .01. If the result of the calculation is less than 150, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 150, the minimum requirement shall be 150 signatures.

This rule is intended to implement Iowa Code chapters 43 and 45.

[**ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—21.602(43) Primary election—nominations by write-in votes for certain offices.

21.602(1) The process described in subrule 21.602(2) shall be used to determine whether the primary election is conclusive and a candidate was nominated for partisan offices that are:

a. Not mentioned in Iowa Code section 43.53 (township offices) or 43.66 (state representative and state senator), and

b. For which no candidate's name was printed on the primary election ballot, and

c. For which no candidate's name was printed on the primary election ballot in any previous primary election.

21.602(2) To be nominated by write-in votes, the person must receive at least 35 percent of the number of votes cast in the previous general election for that party's candidate for president of the United States or for governor, as the case may be, as follows:

a. Statewide office: 35 percent of votes cast statewide.

b. Congressional district: 35 percent of votes cast within the current boundaries of the Congressional district.

c. County office, including plan II supervisors: 35 percent of the votes cast within the county.

d. Plan III county supervisor: 35 percent of the votes cast within the supervisor district. If the boundaries of the supervisor district have changed since the previous general election, the number of votes cast within the county for the party candidate for president or for governor, as the case may be, shall be divided by the number of supervisor districts in the county; then the quotient shall be multiplied by 0.35.

21.602(3) If a write-in candidate is declared nominated at the canvass of votes, Iowa Code section 43.67, which requires the appropriate election commissioner to notify the candidate, shall apply.

This rule is intended to implement Iowa Code section 43.66.

721—21.603 to **21.799** Reserved.

721—21.800(423B) Local sales and services tax elections.

21.800(1) Petitions requesting imposition, rate change, use change, or repeal of local sales and services taxes shall be filed with the county board of supervisors.

a. Each person signing the petition shall include the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition, rate change, use change, or repeal of a local sales and services tax. In the notice the supervisors shall include the date of the election.

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.800(2) As an alternative to the method of initiating a local option tax election described in subrule 21.800(1), governing bodies of cities and the county may initiate a local option tax election by filing motions with the county auditor pursuant to Iowa Code section 423B.1, subsection 4, paragraph *"b,"* requesting submission of a local option tax imposition, rate change, use change, or repeal to the qualified electors. Within 30 days of receiving a sufficient number of motions, the county commissioner shall notify affected jurisdictions of the local option tax election date. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which the commissioner received the motion triggering the election.

21.800(3) Notice of local sales and services tax election.

a. Not less than 60 days before the date that a local sales and services tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include sample ballots, but shall include all of the information that will appear on the ballot for each city and for the voters in the unincorporated areas of the county.

b. The city councils and the supervisors shall provide to the county commissioner the following information to be included in the notice and on the ballots for imposition elections:

(1) The rate of the tax.

(2) The date the tax will be imposed (which shall be the next implementation date provided in Iowa Code section 423B.6 following the date of the election and at least 90 days after the date of the election, except that an election to impose a local option tax on a date immediately following the scheduled repeal date of an existing similar tax may be held at any time that otherwise complies with the requirements of Iowa Code chapter 423B). The imposition date shall be uniform in all areas of the county voting on the tax at the same election.

(3) The approximate amount of local option tax revenues that will be used for property tax relief in the jurisdiction.

(4) A statement of the specific purposes other than property tax relief for which revenues will be expended in the jurisdiction.

c. The information to be included in the notice shall be provided to the commissioner by the city councils of each city in the county not later than 67 days before the date of the election. If a jurisdiction fails to provide the information in subparagraphs 21.800(3)*"b"*(1), 21.800(3)*"b"*(3), and 21.800(3)*"b"*(4) above, the following information shall be substituted in the notice and on the ballot:

(1) One percent (1%) for the rate of the tax.

(2) Zero percent (0%) for property tax relief.

(3) The specific purpose for which the revenues will otherwise be expended is: Any lawful purpose of the city (or county).

d. The notice of election provided for in Iowa Code section 49.53 as amended by 2009 Iowa Acts, House File 475, shall also be published at the time and in the manner specified in that section.

This rule is intended to implement Iowa Code section 423B.1.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.801(423B) Form of ballot for local option tax elections. If questions pertaining to more than one of the authorized local option taxes are submitted at a single election, all of the public measures shall be printed on the same ballot. The form of ballots to be used throughout the state of Iowa for the purpose of submitting questions pertaining to local option taxes shall be as follows:

21.801(1) *Local sales and services tax propositions.* Sales and services tax propositions shall be submitted to the voters of an entire county. If the election is being held for the voters to decide whether to impose the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of imposition shall be voted upon in all parts of the county where the tax has not been approved. If the election is being held for the voters to decide whether to repeal the

tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of repeal shall be voted upon in all parts of the county where the tax was previously imposed. If the election is being held for the voters to decide whether to change the rate or use of the tax in a county where a local option sales and services tax has previously been approved for part of the county, the question of rate or use change shall be voted upon in all parts of the county where the tax was previously imposed.

The ballot submitted to the voters of each incorporated area and the unincorporated area of the county shall show the intended uses for that jurisdiction. The ballot submitted to the voters in contiguous cities within a county shall show the intended uses and repeal dates, if not uniform, for each of the contiguous cities. The ballots shall be in substantially the following form:

a. Imposition question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____ %) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

b. Imposition question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at

the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

c. Imposition question with an automatic repeal date for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

d. Imposition question with an automatic repeal date for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of ____ percent (____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

e. Repeal question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The _____ percent (_____%) local sales and services tax shall be repealed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

f. Repeal question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize repeal of the ____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the

ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The _____ percent (_____%) local sales and services tax shall be repealed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

g. Rate change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to ____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year). The current rate is ____ percent (_____%).

Revenues from the sales and services tax are allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

h. Rate change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax are allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

i. Use change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

Revenues from the sales and services tax are currently allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

j. Use change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

CURRENT USES OF THE TAX:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues are otherwise expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

k. Imposition question with differing automatic repeal dates for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until automatic repeal date specified.

A local sales and services tax shall be imposed in the following cities at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until the date specified below and the revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

21.801(2) *For a local vehicle tax:*

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Summary: To authorize the county of (insert name of county) to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes from the tax:

_____.

The revenues are to be expended as set forth in the text of the public measure.

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using optical scan ballots which are read by automatic tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The county of _____, Iowa shall be authorized to impose a local vehicle tax at the rate of _____ dollars ($_____) per vehicle and to exempt the following classes of vehicles from the tax:

_____

_____ (insert percentage or dollar amount) of the revenues is/are to be used for property tax relief.

The balance of the revenues is to be expended for:

(List purposes for which remaining revenues will be used)

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.802(423B) Local vehicle tax elections.

21.802(1) Petitions requesting imposition of local vehicle taxes shall be filed with the county board of supervisors.

a. Each person signing the petition shall add the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition of a local vehicle tax. In the notice the supervisors shall include the date of the election.

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph *"c,"* but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.802(2) Notice of local vehicle tax election. Not less than 60 days before the date that a local vehicle tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include a sample ballot, but shall include all of the information that will appear on the ballot. The notice of election provided for in Iowa Code section 49.53 as amended by 2009 Iowa Acts, House File 475, shall also be published at the time and in the manner specified in that section.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09]

721—21.803(82GA,HF2663) Revenue purpose statement ballots. When a school district wishes to adopt, amend or extend the revenue purpose statement specifying the uses of the funds received from the secure an advanced vision for education fund, which is also referred to as the "penny sales and services tax for schools," the following ballot formats shall be used.

21.803(1) *Ballot to propose a revenue purpose statement.* The ballot for an election to propose a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To adopt a revenue purpose statement specifying the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the following revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be adopted:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

21.803(2) *Ballot to amend a revenue purpose statement.* The ballot for an election to decide a change in the revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To authorize a change in the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be changed.

Proposed uses. If the change is approved, the revenue purpose statement shall read as follows:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

Current uses. If the change is not approved, the funds shall continue to be used as follows:

(Insert here the current revenue purpose statement or list the current voter-approved uses of the funds by the school district, if the school infrastructure local option tax was adopted before the revenue purpose statement was required.)

21.803(3) *Ballot to extend a revenue purpose statement.* The ballot for an election to extend a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: To authorize _____ School District to continue to spend money from the penny sales and services tax for schools for the previously approved uses until (specify date or insert amended date).

_____ School District is authorized to extend the current revenue purpose statement which specifies use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) received from (date) until (specify date or insert amended date). If an extension is not approved, the current revenue purpose statement will expire on (date). If an extension is approved, the revenue purpose statement will read as follows:

(Insert here the revenue purpose statement, including the new expiration date. If there is not a predicted expiration date, the ballot language must state that the revenue purpose statement will remain in effect until it is changed.)

This rule is intended to implement 2008 Iowa Acts, House File 2663, section 29.

721—21.804 to **21.809** Reserved.

721—21.810(34A) Referendum on enhanced 911 emergency telephone communication system funding.

21.810(1) *Form of ballot.* The ballot for the E911 referendum shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area).

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount to be determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on the map below."

21.810(2) *Cost of election.* The E911 service board shall pay the costs of the referendum election.

21.810(3) *Enhanced 911 emergency service funding referendum held in conjunction with a scheduled election.*

a. Notice to commissioner. The joint E911 service board shall notify the commissioner in writing, no later than the last day upon which nomination papers may be filed, of their intention to conduct the referendum with the scheduled election. The notice shall contain the complete text of the referendum question including the description of the proposed E911 service area. If a map is to be used on the ballot to describe the proposed E911 service area, the map shall be included. If the E911 service area includes more than one county, the service board shall notify the commissioner of each of the counties.

b. Conduct of election. All qualified electors in a precinct which is to be served, in whole or in part, by the proposed E911 service area, shall be permitted to vote on the question. The results of the referendum shall be canvassed by the board of supervisors at the time of the canvass of the scheduled election. The commissioner shall immediately certify the results to the joint E911 board.

c. Service board duties. If subscribers from more than one county are included within the proposed service area, the E911 service board shall meet as a board of canvassers to compile the results from the counties. The canvass shall be held on the tenth day following the election at a time established by the E911 service board. The service board shall prepare an abstract showing in words and numbers the

number of votes cast for and against the question and, if a simple majority of those voting on the question has voted in the affirmative, the board shall declare that the surcharge has been adopted. Votes cast and not counted as a vote for or against the question shall not be used in computing the total vote cast for and against the question.

21.810(4) *Form of ballot for alternative surcharge.* The ballot for elections conducted pursuant to Iowa Code section 34A.6A shall be in the following form:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES □
NO □

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed service area). The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line.

A map may be used to show the proposed E911 service area. If a map is used the public measure shall read as follows:

"Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a temporary monthly surcharge increase to (an amount between one dollar and two dollars and fifty cents to be determined by the local joint E911 service board) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within the proposed E911 service area shown on the map below. The surcharge shall be collected for not more than 24 months, after which the surcharge shall revert to one dollar per month for each line."

This rule is intended to implement Iowa Code sections 34A.6 and 34A.6A.

721—21.811 to **21.819** Reserved.

721—21.820(99F) Gambling elections.

21.820(1) Petitions requesting elections to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure shall be filed with the county board of supervisors and shall be substantially in the form posted on the state commissioner's Web site titled "Petition Requesting Special Election."

a. Within 10 days after receipt of a valid petition, the supervisors shall provide written notice to the county commissioner of elections directing the commissioner to submit to the qualified electors of the county a proposition to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure in the county. The election shall be held on the next possible special election date pursuant to Iowa Code section 39.2, subsection 4, paragraph *"a,"* but no fewer than 46 days from the date notice is given to the county commissioner.

b. If a regularly scheduled or special election is to be held in the county on the date selected by the supervisors, notice shall be given to the commissioner no later than the last day upon which nomination papers may be filed for that election. If the excursion gambling boat or the gambling structure election is to be held with a local option tax election, the supervisors shall provide the commissioner at least 60 days' written notice. Otherwise, the supervisors shall give at least 46 days' written notice.

21.820(2) Form of ballot for election called by petition. Ballots shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

21.820(3) Form of ballot for elections to continue gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

Gambling games, with no wager or loss limits, on an excursion gambling boat or at a gambling structure in _____ County are approved. If approved by a majority of the voters, operation of gambling games with no wager or loss limits may continue until the question is voted upon again at the general election held in 2010. If disapproved by a majority of the voters, the operation of gambling games on an excursion gambling boat or at a gambling structure will end within 60 days of this election. (Iowa Code section 99F.7(10)*"c"*)

21.820(4) Ballot form to permit gambling games at existing pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

The operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

21.820(5) Abstract of votes. A copy of the abstract of votes of the election shall be sent to the state racing and gaming commission.

21.820(6) Ballot form for general election for continuing operation of gambling games at pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue at (name of pari-mutuel racetrack) in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of the voters, gambling games at (name of pari-mutuel racetrack) in _____ County will end.

21.820(7) Ballot form for general election for continuing gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

⬭ YES

⬭ NO

Summary: The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved.

The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue on an excursion gambling boat or at a gambling structure in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of voters, gambling games on an excursion gambling boat or at a gambling structure in _____ County will end nine years from the date of the original issue of the license to the current licensee.

This rule is intended to implement Iowa Code section 99F.7 and Iowa Code Supplement section 99F.4D.

[**ARC 8045B**, IAB 8/26/09, effective 7/27/09; **ARC 8779B**, IAB 6/2/10, effective 7/1/10]

721—21.821 to **21.829** Reserved.

721—21.830(357E) Benefited recreational lake district elections. Elections for benefited recreational lake districts shall be conducted according to the following procedures.

21.830(1) *Conduct of election.* It is not mandatory for the county commissioner of elections to conduct elections for a benefited recreational lake district. However, if both a public measure and a candidate election will be held on the same day in a benefited recreational lake district, the same person shall be responsible for conducting both elections. All elections must be held on a Tuesday.

21.830(2) *Ballots.* Ballots for benefited recreational lake district trustee elections shall be printed on opaque white paper, 8 by 11 inches in size. The ballots for the initial election for the office of trustee shall be in substantially the following form:

OFFICIAL BALLOT
BENEFITED RECREATIONAL LAKE DISTRICT
Election date
(facsimile signature of person responsible for printing ballots)

FOR TRUSTEE:

To vote: Neatly print the names of at least three people you would like to see elected to the office of Trustee of the Benefited Recreational Lake District. You may vote for as many people as you wish, but you must vote for at least three.

(At the bottom of the ballot a space shall be included for the endorsement of the precinct election official, like this:)

Precinct official's endorsement: _____

21.830(3) *Canvass of votes.* On the Monday following the election, the board of supervisors shall canvass the votes cast at the election. At the initial election the supervisors shall choose three trustees

from among the five persons who received the most votes. The results of benefited recreational lake district elections shall be certified to the district board of trustees.

This rule is intended to implement Iowa Code section 357E.8.

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◊ Two or more ARCs

CHAPTER 22
VOTING SYSTEMS

[Prior to 7/13/88, see Secretary of State[750] Ch 10]

TESTING AND EXAMINATION OF VOTING EQUIPMENT

721—22.1(52) Definitions for certification of voting equipment.

"Accredited independent test authority" means a person or agency that was formally recognized by the National Association of State Election Directors as competent to design and perform qualification tests for voting system hardware and software. "Accredited independent test authority" also includes voting system test laboratories accredited by the Election Assistance Commission to test voting systems for compliance with federal voting system standards and guidelines, as required by the Help America Vote Act, Section 231.

"Audio ballot" means the presentation of the contents of a ballot on an electronic ballot marking device in a recorded format, played to the voter over headphones.

"Automatic tabulating equipment" means apparatus that are utilized to ascertain the manner in which optical scan ballots have been marked by voters or by electronic ballot marking devices and to count the votes marked on the ballots.

"Ballot" means the official document that includes all of the offices or public measures to be voted upon at a single election, whether they appear on one or more paper ballots. The term includes optical scan paper ballots designed to be read by automatic tabulating equipment. In appropriate contexts, "ballot" also includes conventional paper ballots.

"Ballot marking device" means a pen, pencil, or similar writing tool, or an electronic device, all designed for use in marking an optical scan ballot, and so designed or fabricated that the mark it leaves may be detected and the vote so cast counted by automatic tabulating equipment.

"Certification" means formal approval of an optical scan voting system for use in Iowa pursuant to Iowa Code sections 52.5 and 52.26.

"De minimis change" means a change to a certified voting system's hardware, the nature of which will not materially alter the system's reliability, functionality, capability, security and operation. In order for a change to qualify as a de minimis change, it must not alter the reliability, functionality, capability, security and operability of the system. A de minimis change shall also ensure that when the hardware is replaced, the original hardware and the replacement hardware are electronically and mechanically interchangeable and have identical functionality and tolerances. A change shall not be considered de minimis if it has reasonable and identifiable potential to affect the system's operation and compliance with applicable voting system standards.

"Early voting" means the process of receiving ballots from voters before election day without using absentee voting procedures. Iowa law does not authorize this process.

"Electronic ballot marking device" means a component of an optical scan voting system designed to assist voters with disabilities by displaying audio and visual ballot information to the voter, providing accessible methods for the voter to make selections, and then printing the voter's choices on an optical scan ballot.

"Electronic transmission" means using hardware and software components to send data over distances both within and external to the polling place and to receive an accurate copy of the transmission.

"Examiners" means the board of examiners for voting systems described in Iowa Code section 52.4.

"Modification" means a change to a certified voting system's software or firmware. Modification also means a change to a certified voting system's hardware that has the potential to affect the reliability, functionality, capability, security or operability of a system.

"Optical scan ballot" means a printed ballot designed to be marked by a voter with a ballot marking device and to be counted by use of automatic tabulating equipment.

"Optical scan voting system" means a system employing paper ballots under which votes are cast by voters by marking paper ballots with a ballot marking device and thereafter counted by use of automatic tabulating equipment.

"Program" means the written record of the set of instructions defining the operations to be performed by a computer in examining, counting, tabulating, and printing votes.

"Qualification test" means the examination and testing of a voting system by an independent test authority using the voting system standards required by Iowa Code section 52.5 and rule 721—22.2(52) to determine whether the system complies with those standards.

"Vendor" means a person or representative of a person owning or being interested in an optical scan voting system and seeking certification of the equipment for use in elections in Iowa.

"Voting booth" means an enclosure designed to be used by a voter while marking a conventional paper ballot, optical scan ballot or ballot card.

"Voting equipment" means an optical scan voting system which is required by Iowa Code sections 52.5 and 52.26 to be approved for use by the examiners.

"Voting system" means the total combination of mechanical, electromechanical or electronic equipment (including the software, firmware and documentation required to program, control and support the equipment that is used to define ballots, to cast and count votes, to report or display election results and to maintain and produce any audit trail information). "Voting system" also includes the practices and associated documentation used to identify system components and versions of such components, to test the system during its development and maintenance, to maintain records of system errors and defects, to determine specific system changes to be made to a system after the initial qualification of the system and to make available any materials to the voter such as notices, instructions, forms or paper ballots. (See Section 301(b) of HAVA.)

[**ARC 8244B**, IAB 10/21/09, effective 10/2/09; **ARC 9468B**, IAB 4/20/11, effective 5/25/11]

721—22.2(52) Voting system standards. All electronic voting systems approved for use by the board of examiners after April 9, 2003, shall meet Voting Systems Performance and Test Standards, as adopted by the Federal Election Commission April 30, 2002, or the 2005 Voluntary Voting Systems Guidelines, as adopted by the U.S. Election Assistance Commission in December 2005. The report of an accredited independent test authority certifying that the system is in compliance with these standards shall be submitted with the application for examination.

This rule is intended to implement Iowa Code section 52.5.

[**ARC 9468B**, IAB 4/20/11, effective 5/25/11; **ARC 9762B**, IAB 10/5/11, effective 9/8/11]

721—22.3(52) Examiners. The examiners annually shall elect a chairperson. All three examiners must be present for any formal action. Approval by two of the three examiners is required to approve any action to be taken by the examiners.

22.3(1) Notice of the time and place of any meeting by the board of examiners must be published pursuant to Iowa Code section 21.4.

22.3(2) Meetings of the examiners are open to the public, except that closed meetings may be held as permitted by Iowa Code section 21.5.

22.3(3) Correspondence and materials required to be filed with the board of examiners shall be addressed to the examiners in care of the Elections Division, Office of the Secretary of State, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

721—22.4(52) Fees and expenses paid to the examiners.

22.4(1) The examiners shall be reimbursed for travel to and from the meeting place at the rate specified in Iowa Code section 70A.9. The examiners shall also be reimbursed for actual expenses for meals and lodging, if necessary.

a. If the meeting was called for the purpose of examining, reexamining, testing, or discussing the certification of voting equipment offered by a vendor, the examiners' expenses shall be paid by the vendor within seven days following the completion of the examination and testing of the voting equipment.

b. If the meeting was called for the purpose of advising the secretary of state regarding administrative rules for the examiners, or to hear complaints or requests for decertification of voting equipment, or any other business of interest to the examiners, the expenses shall be paid by the secretary of state.

22.4(2) The vendor shall pay the examiners the amount of compensation specified in Iowa Code section 52.6 at the beginning of each meeting for which compensation is required to be provided to the examiners. The fee shall be paid as follows:

a. For each meeting or series of meetings held for the purpose of certifying an optical scan voting system or component thereof.

b. For each meeting or series of meetings for reconsideration of an optical scan voting system or component thereof after denial of certification.

This rule is intended to implement Iowa Code sections 17A.19, 49.25(3), 52.5, 52.6, and 52.26.
[**ARC 8244B**, IAB 10/21/09, effective 10/2/09]

721—22.5(52) Examination of voting equipment—application. Any vendor who wishes to apply for certification of voting equipment for use in the state of Iowa shall apply to the secretary of state for an appointment with the examiners. The application shall include five copies of each of the following:

22.5(1) History of the equipment to be examined. This history shall include a complete description of the equipment to be examined, descriptions of any previous models of the equipment, the date the system to be examined went into production, and a complete list of jurisdictions which have used the equipment. The user list shall include jurisdictions which used the equipment experimentally without purchasing it, jurisdictions which purchased earlier versions of the equipment to be examined, and jurisdictions which purchased the current version of the equipment to be examined.

22.5(2) Copies of all manuals developed for use with the system including, but not limited to, technical manuals for repair and maintenance of the equipment, operations manuals for election officials, printer's manuals for ballot production, and any other written documents prepared by the vendor that describe the operation, use, and maintenance of the machine.

22.5(3) Report of an accredited independent test authority certifying that the system is in compliance with the voting systems standards required by rule 721—22.2(52). Copies of these reports are confidential records as defined by Iowa Code section 22.7 and Iowa Code chapter 550. Independent test authority reports shall be available to the secretary of state, deputy secretary of state, director of elections, members of the board of examiners, and any other person designated by the secretary of state to have a bona fide need to review the report. No other person shall have access to the reports, and no copies shall be made. All independent test authority reports shall be marked "CONFIDENTIAL" and shall also be accompanied by a list of those persons who are authorized to examine the report. The reports shall be kept in a locked cabinet.

22.5(4) Copies of the reports of any test authority who has examined the equipment in conjunction with certification requirements of other states.

22.5(5) Reports of the certifying authorities of any other states that have examined the equipment, whether or not the equipment was approved for use.

22.5(6) Brochures, photographs and advertising material used to encourage sales of the equipment.

22.5(7) Manuals for the use and maintenance of any components of the equipment that are not manufactured by the vendor.

22.5(8) Rescinded IAB 4/20/11, effective 5/25/11.

22.5(9) Reserved.

22.5(10) The form prescribed by the state commissioner of elections to request examination and testing of voting systems.
[**ARC 8244B**, IAB 10/21/09, effective 10/2/09; **ARC 9468B**, IAB 4/20/11, effective 5/25/11]

721—22.6(52) Review of application by examiners. Upon receipt of the application, the secretary of state shall immediately forward copies of the application to each of the examiners. The examiners shall review the application and within seven days a date shall be set for the examiners to meet and examine

the equipment. If additional information is needed by the examiners, they may delay setting a date for the examination pending the submission of the requested materials.

721—22.7(52) Consultant. If the examiners determine that a consultant is necessary to determine whether a system meets the requirements of Iowa law or whether a change to a voting system is de minimis or a modification, the examiners shall notify the vendor of the decision. The vendor may suggest the names of reliable independent test authorities to the examiners and may decline to submit the equipment to the examination of an individual for good reason.

A consultant may be employed if no other state has certified the equipment for use. The examiners may require a consultant if the equipment has been modified following certification by other states, or if the examiners believe it to be necessary.

If a test authority has been determined to be necessary by the examiners and a suitable consultant cannot be agreed upon by the examiners and the vendor, the equipment shall not be approved for use.
[**ARC 8244B**, IAB 10/21/09, effective 10/2/09]

721—22.8(52) Contact other users. The examiners shall contact a representative sample of the users of the equipment to determine the nature of the experience of other users.

721—22.9(52) Testing the equipment. The vendor shall provide to the examiners one, or more, if deemed necessary by the examiners, production models of the equipment submitted for certification. The equipment shall be prepared by the examiners with the aid of the vendor to be tested at two sample elections: a sample partisan primary election, and a sample general election.

22.9(1) Test county for absentee voting. Voting equipment which is designed to be used for tabulation of absentee ballots shall be tested using a model county consisting of 155 precincts, with 180,000 registered voters. The county shall include one U.S. congressional district, five state senate districts, 11 state house of representatives districts, and 30 townships. Each township shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(2) Test county for absentee systems. Voting equipment which is designed to be used for tabulation of absentee ballots only shall be tested using a model county consisting of 155 precincts, with 180,000 registered voters. The county shall include one U.S. Congressional District, five state senate districts, 11 state house of representatives districts, and 30 townships. Each township shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(3) Test precinct for precinct count systems. The test precinct shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(4) All requirements for preparation and printing of test ballots shall be met in the preparation of ballots for the test elections including, but not limited to, rotation of candidates' names and the provision of space for write-in votes.

22.9(5) Test ballots provided by vendor. The vendor shall provide the ballots to be used in the testing of the equipment. A total of at least 2000 ballots shall be printed for each of the two test elections. One thousand ballots for each test election shall be marked and manually tabulated by the vendor to use as a test of the ability to tabulate results accurately. The balance of the ballots shall be delivered to the examiners before the date set for the examination. The examiners shall mark and manually tabulate an additional set of at least 300 test ballots.

721—22.10(52) Test primary election for three political parties.

22.10(1) *Closed primary election.* Voters may only cast votes for the candidates of one of the parties.

22.10(2) *Offices.* The following offices shall each have two candidates for each party. Candidate names shall be rotated as required by Iowa Code section 43.28.

a. U.S. Senator

b. U.S. Representative

c. Governor
d. Secretary of State
e. Auditor of State
f. Treasurer of State
g. Secretary of Agriculture
h. Attorney General
i. State Senator
j. State Representative
k. County Supervisor (vote for no more than three of six candidates)
l. County Treasurer
m. County Recorder
n. County Attorney
o. and *p.* Rescinded IAB 8/1/07, effective 7/13/07.

22.10(3) *Write-in votes.* Spaces for write-in votes shall be provided for each office on the ballot. The number of spaces shall equal the number of persons to be elected to the office.

721—22.11(52) Test general election. The ballots for the test general election shall include the following:

22.11(1) Offices. In the test general election all of the above offices shall be included with the addition of candidates for lieutenant governor to be voted for jointly with each candidate for governor. Each political party and nonparty political organization shall have one candidate for each office that appeared on the primary ballot, except county supervisor, which shall have three candidates for each party and nonparty political organization. Names of candidates for county supervisor shall be rotated as required by Iowa Code section 49.31, subsection 2.

The following nonpartisan offices shall also be included on the ballot with the heading "Nominated by Petition":

a. Township Trustee
b. Township Clerk
c. County Public Hospital Trustee
d. Soil and Water Conservation District Commissioners
e. Agricultural Extension Council

22.11(2) Judicial ballot. Portions of the judicial ballot may be printed separately if necessary.

a. Supreme Court (five justices)
b. Appeals (four judges)
c. District Court (six judges)
d. District Associate Judges (three judges)

22.11(3) Public measures.

a. Constitutional Amendments (two)
b. Local public measures (three)

22.11(4) Straight party voting for three political parties and five nonparty political organizations.

22.11(5) Write-in votes. Spaces for write-in votes shall be provided for each office on the ballot. The number of spaces shall equal the number of persons to be elected to the office. This does not include judges standing for retention.

721—22.12(52) Report of findings. The examiners shall complete a report showing their findings. The report shall include a checklist containing all statutory requirements for voting systems and shall indicate whether each requirement applies to the voting system being examined and whether the voting system is compliant or not compliant. The checklist must indicate that all applicable items are compliant with statutory requirements in order for the examiners to find that the voting system may be approved for use.

22.12(1) *Approval permits use.* If the report states that the voting system has been approved for use, the voting system may be adopted for use at elections.

22.12(2) *Report filed with the secretary of state.* The report shall be filed with the secretary of state. The secretary of state shall retain the vendor's application and other documents submitted pertaining to the certification as long as the voting system remains certified.

721—22.13(52) Notification. The examiners shall promptly notify the vendor of their decision and shall provide the vendor with a copy of their report.

721—22.14(52) Denial of certification. If the examiners find that the equipment does not meet the requirements prescribed by the Code of Iowa and the Iowa Administrative Code, the examiners shall deny certification to the equipment. The report of the board shall specify the reasons for the denial, as well as all areas in which the equipment complied with the requirements of the law. Certification may be denied for any of the following reasons:

22.14(1) The absence of any feature required by Iowa Code section 52.5 or 52.26.

22.14(2) Failure to pay the examiners' fees and expenses, or the fees of any consultant mutually agreed upon by the examiners and the vendor.

22.14(3) Failure to provide the examiners with a complete application as required by rule 721—22.5(52).

22.14(4) Failure of the equipment to produce accurate results in one or both of the test elections. The test groups of ballots shall be tabulated manually to determine the expected outcome of each test election. If the equipment fails to reproduce exactly the results of the manual tabulation, the system shall not be approved for use, unless it can be demonstrated that the manual tabulation was in error and the machine tabulation was accurate.

[**ARC 9468B**, IAB 4/20/11, effective 5/25/11]

721—22.15(52) Application for reconsideration. Following denial of certification a vendor may make the necessary modifications to the system and apply for reconsideration. Aspects of the equipment which were approved in the initial application do not need to be reexamined unless the examiners find that the modifications may have affected the ability of the equipment to comply in other areas. If certification was denied for the reasons cited in 22.14(1) or 22.14(4), both test elections must be completed satisfactorily, or approval shall not be granted.

721—22.16(52) Appeal. If the vendor believes the denial of certification is in error, the vendor must file written exceptions with the examiners within 30 days after issuance of the report. The examiners will issue a response to the exceptions within 30 days after filing of the exceptions. A vendor who is aggrieved or adversely affected by a denial after a ruling on exceptions may seek judicial review pursuant to Iowa Code section 17A.19.

721—22.17(52) Changes to certified voting systems. The procedures in this rule shall be followed anytime a change is made to a certified voting system, including a change in tabulation software, firmware, or hardware.

22.17(1) *Notification of change.* The vendor shall notify the examiners of any changes in a certified voting system. The vendor shall provide the examiners with the following information at the time the vendor provides notice of the change(s):

a. A description of the changes made.

b. Reports of test results conducted by an accredited independent test authority, and any reports of test results conducted by or for other states following the changes to the voting system.

c. Copies of manuals, instructions, advertisements and other documents submitted with the voting system's original application for certification that have been updated since the original application was submitted.

d. An assessment from an accredited independent test authority of the change as either a de minimis change or a modification to the voting system.

22.17(2) *Commencing review proceedings.* Within seven days of receiving a voting system change notice from a vendor, the examiners shall commence review proceedings to independently determine

whether the change submitted by the vendor is a de minimis change or a modification to the voting system. In making this independent determination, the examiners may use any means available, including hiring a consultant pursuant to rule 721—22.7(52).

22.17(3) *De minimis changes.* If the examiners determine a change to a voting system is de minimis, the examiners may approve the changes by motion and certify the changed voting system for use in the state.

22.17(4) *Modifications to voting systems.* If the examiners determine a change to a voting system is a modification to the voting system, the examiners shall require the vendor to submit a new application for certification and testing of the voting system pursuant to rules 721—22.5(52) to 721—22.11(52).
[**ARC 8244B**, IAB 10/21/09, effective 10/2/09]

721—22.18(52) Rescinding certification.

22.18(1) *Grounds for rescinding certification.* Certification may be rescinded if it is found that:

a. The equipment does not produce accurate results and reports as required for an election.

b. Modifications have been made in a certified voting system that have not been approved by the examiners.

c. Equipment which has been certified for use has not been adopted by any county in Iowa, or is no longer used by any county in Iowa, and is no longer available for purchase from the manufacturer. The examiners may rescind certification of such voting equipment without a complaint or contested case proceedings.

d. Equipment that has been certified for use no longer complies with the requirements of Iowa law.

e. Any other grounds that may materially affect delivery or performance of the equipment.

22.18(2) *Procedure for rescinding certification.* Complaints regarding voting equipment certified for use in Iowa shall be filed with the secretary of state. The examiners shall review all complaints and may initiate a contested case to rescind certification on any ground listed above. The contested case may be conducted before the examiners or before an administrative law judge. A contested case for rescinding certification shall be conducted, to the extent applicable, in accordance with the procedural rules specified in 481—Chapter 10, Iowa Administrative Code.

22.18(3) *Suspension of certification.* If the administrative law judge hearing the contested case, or the examiners, as the case may be, find that the voting equipment can be modified to correct the deficiency, certification may be suspended until the deficiency is corrected. If it is found that the deficiency is limited to a specific flaw not present in all models of the equipment, the suspension may be limited to the deficient models. While certification is suspended, the equipment may not be used for any election.

After the required modifications have been made the vendor may apply for reexamination of the equipment following the procedure described in rule 721—22.17(52).

22.18(4) *Further use prohibited.* If certification of voting equipment is rescinded without qualification, no further use shall be permitted by any county.
[**ARC 8244B**, IAB 10/21/09, effective 10/2/09]

These rules are intended to implement Iowa Code sections 17A.12, 21.4, 21.5, 52.4, 52.5, 52.6, 52.7, 52.26, and 70A.9.

721—22.19(52) Examination of voting booths—application. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.20(52) Review of application by examiners. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.21(52) Contact other users. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.22(52) Criteria for approval. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.23(52) Report. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.24(52) Notification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.25(52) Denial of certification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.26(52) Application for reconsideration. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.27(52) Appeal. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.28(52) Reexamination following changes in voting booth. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.29(52) Rescinding certification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.30(50,52) Electronic transmission of election results.

22.30(1) *Certification of equipment.* On or after December 17, 2003, new components for transmission of election results by any electronic means may be used in elections in Iowa only if the components are approved by the board of examiners for use with a certified voting system. Existing systems containing electronic transmission components in use before December 17, 2003, may continue to be used until January 1, 2006, when the Help America Vote Act voting system requirements become effective.

The examiners shall review the qualification test report submitted with the application for examination and testing of the voting system. If the test report for the voting system under examination shows that the electronic transmission components have met the voting system standards and the examiners concur, the electronic transmission components may be used in conjunction with the voting system. If the qualification test report or the examiners conclude that the electronic transmission components do not meet the voting system standards, or if this feature is not mentioned in the report, purchasers of the voting system may not transmit election results electronically.

22.30(2) *Procedures on election day.* The election results may be transmitted electronically from voting equipment to the county commissioner of elections' office only after the precinct election officials have produced a written report of the election results as required by Iowa Code section 50.11. All election officials of the precinct shall sign the printed report of the election results. The signed copy shall be the official tabulation from that precinct.

22.30(3) *Procedures after election day.* Before the canvass by the board of supervisors, the county commissioner of elections shall compare the signed, printed report from each precinct with the results transmitted electronically from the precinct on election night. The commissioner shall report any discrepancies between the two sets of election results to the board of supervisors. The signed, printed results produced pursuant to Iowa Code section 50.11 shall be considered the correct results.

This rule is intended to implement Iowa Code sections 50.11 and 52.41.

721—22.31(52) Acceptance testing. When the commissioner receives voting equipment from a vendor, the commissioner shall carefully examine and test the equipment to:

22.31(1) Verify that the system delivered is certified for use in Iowa. The commissioner shall compare the voting system version numbers with the list of certified voting equipment provided by the state commissioner;

22.31(2) Verify that everything in the contract has been delivered by:

a. Comparing a copy of the purchase contract with the items received;

b. Making certain that all components, such as power cords, casters, and keys, are included;

c. Reviewing instruction and maintenance manuals to be sure that the correct version of each manual was provided; and

22.31(3) Verify that everything delivered actually works. The commissioner shall run a simulated election to confirm that each part of the system and the system as a whole function properly.

721—22.32(52) Optical scan voting system purchase program. Rescinded IAB 4/20/11, effective 5/25/11.

721—22.33 to **22.38** Reserved.

721—22.39(52) Public testing for direct recording electronic voting machines. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.40(52) Public testing of lever voting machines. Rescinded IAB 8/1/07, effective 7/13/07.

721—22.41(52) Public testing of optical scan systems. All automatic tabulating equipment (including equipment used to tabulate absentee ballots) shall be tested before use at any election, as required by Iowa Code section 52.35. The process and results of the test shall be documented and available for inspection.

22.41(1) Each automatic tabulating device (including equipment that will be used for counting absentee ballots) shall be tested to determine the following:

a. The device and its programs will accurately tabulate votes for each candidate and question on the ballot.

b. Votes cast for more candidates for any office than the number to be elected will result in the rejection of all votes cast for that office on that ballot. Votes properly cast for other offices on the same ballot shall be counted.

c. The tabulating equipment records all votes cast and no others. A written tally of the test votes shall be prepared before the test. The results of the test voting shall be recorded. The results of the machine tabulation shall be printed and compared with the test plan.

d. The voter may cast as many write-in votes for each office on the ballot as there are positions to be filled, and the write-in votes are tallied correctly.

e. For primary elections, the tabulating equipment accurately records votes cast for all political parties.

f. For general elections:

(1) A ballot marked with only a straight party vote is recorded with one vote for each candidate of the designated political party, and no other votes are recorded for partisan offices;

(2) The voter may override a straight party vote for any office by voting for any candidate not associated with that political party; and

(3) For offices to which more than one person will be elected, if a voter has chosen to override a straight party vote, only the candidates whose names are marked shall receive a vote.

22.41(2) Conducting the test.

a. The commissioner shall follow the process described in rule 721—22.42(52) for preparing test decks.

b. If, during the test, there are differences between the test plan and the results produced by the optical scan device, the cause of the discrepancy shall be determined. If the cause of the discrepancy cannot be determined and corrected, the faulty program or equipment shall not be used in the election.

c. The test decks, the preparer's tally, and the printed results of the test shall be kept with the records of the election and preserved as required by Iowa Code section 50.19.

721—22.42(52) Preparing test decks. The commissioner shall prepare test decks from all ballots printed for use in the election, including those for use at the polling places and for absentee balloting. Each of the following test decks shall be prepared for every precinct and ballot style in the election. Commissioners may use additional test methods to supplement the process described in this rule.

22.42(1) *Requirements for all test decks prepared by the commissioner and used in public testing.* The commissioner shall:

a. Replace ballots spoiled during the marking process instead of attempting to correct errors.

b. Fill in each oval completely using the recommended pen, pencil or AutoMARK VAT.

c. Mark each ballot "Test Ballot."

22.42(2) *Required test method.* The commissioner shall:

a. Prepare a test plan showing the planned number of votes, including undervotes and overvotes for each oval on the ballot. Follow the instructions in subrules 22.42(3) through 22.42(5) in preparing the test decks.

b. Mark the test ballots according to the test plan.

c. Print a zero totals report from the optical scan tabulator before inserting any ballots.

d. Insert the ballots into the optical scan tabulator and print a report showing the number of votes recorded for all offices, questions and judges, including undervotes and overvotes.

e. Compare the printed report with the test plan to ensure that the correct number of votes was counted for each oval.

f. If the commissioner finds errors, the commissioner shall identify and correct them. The commissioner shall repeat the testing process until the printed results from the tabulator match the test plan. If the commissioner cannot produce an errorless test, the equipment shall not be used in the election.

22.42(3) *Systematic test deck.* The commissioner shall determine a unique number of votes for each candidate in each office, such as one vote for each write-in oval for the office, two votes for the first candidate listed (or "NO" votes on public measures and judges), three votes for the second candidate, etc. It is not necessary to have a different number of votes for each write-in oval for offices for which the voter may select more than one candidate. However, the write-in oval shall have a different number of votes marked than any candidate for the office. The commissioner shall:

a. On general election ballots, leave the straight party choice blank.

b. For offices without candidates, mark all of the write-in ovals for that office.

c. For offices in which the voter may vote for more than one candidate, vote for the maximum allowed on at least one ballot.

d. On a ballot that contains at least one valid vote, overvote one other office or question.

22.42(4) *System-specific testing requirements.* Separate tests are prescribed for each certified voting system.

a. Election Systems & Software—overvote and blank ballot test. For an overvote and blank ballot test, the commissioner shall:

(1) Overvote all offices and questions (including judges) on one ballot, by marking one more vote than permitted. Do not mark the write-in ovals for any offices for which there are no candidates' names on the ballot.

(2) If the test is for ballots that will be used in a general election, mark two straight party votes on one ballot. Do not mark any other ovals. In the test plan, this ballot should be tallied to show that the straight party selection was overvoted, and to show undervotes for all other offices and questions on the ballot.

(3) When the overvoted ballots are rejected by the optical scan tabulator, override the rejection and include the ballot in the tally. Add to the manual tally the number of overvotes in this test. The tally for this part of the test deck will show no votes for any candidate.

(4) Insert a blank ballot. This is a very important test of the accuracy of ballot printing. Printing errors sometimes put readable marks in the voting target area.

(5) Orientation test. Mark the maximum number of choices for each office and question on one ballot.

Scan this ballot in each of the four possible orientations:

- Face up, head first.
- Face down, head first.
- Face up, feet first.
- Face down, feet first.

b. Premier Election Solutions.

(1) Blank and fully voted test. The commissioner shall use two ballots for this test.

1. Leave one ballot completely blank.
2. On the second ballot, mark every oval on both sides of the ballot.

3. Select "Test Blank Ballots" and insert the blank ballot in all four orientations:
- Face up, head first.
- Face down, head first.
- Face up, feet first.
- Face down, feet first.

4. Select "Test Fully Voted Ballots" and insert the second ballot in each of the four orientations listed in numbered paragraph "3" above.

5. Reinsert the blank ballot and the fully voted ballot and override the rejection feature.

(2) Overvote. Overvote all offices and questions (including judges) on one ballot, by marking one more vote than permitted. Do not mark the write-in ovals for any offices for which there are no candidates' names on the ballot.

22.42(5) *Straight party test for general elections.* For a straight party test, the commissioner shall:

a. For each set of ballots:

(1) Mark straight party votes in a pattern, such as one vote for the first straight party choice, two votes for the second, and so on, and tally the expected results. Do not mark anything else on this group of ballots.

(2) On a second set of ballots containing as many ballots as there are straight party choices, mark the straight party option and, for each office affected by the straight party vote, mark the write-in oval, and tally the expected results.

(3) If the election includes an at-large county supervisor race with more than one person to be elected, mark a ballot with only a straight party vote and then vote for one candidate from the same political party as the straight party vote. Only this separately marked candidate should receive a vote.

b. Compile the results of the straight party test deck.

721—22.43(52) Conducting the public test.

22.43(1) The equipment shall be inspected to determine whether it has been prepared properly for the election at which it will be used. The following information shall be verified:

a. The correct program cartridge or memory card is in place for the election and the precinct or precincts in which it will be used.

b. All counters are set at zero before the test is begun.

22.43(2) The commissioner shall conclude the test not later than 12 hours before the polls open on election day. Following the test, the tabulating equipment shall be inspected to determine that:

a. All counters have been returned to zero.

b. All required locks or seals are in place.

c. The automatic tabulating equipment is ready for operation at the election.

The results tape from each scanner produced during the public test shall be signed by the person conducting the test and by any observers present at the test. The signers shall write their signatures at the end of the tape where it will be detached from the machine. The tape shall be torn or cut across the signatures, so that a portion of the signature is on the tape remaining on the tabulating device. The test results tape, including a part of the tester's signature, shall be retained with the appropriate test deck for the period of time required by Iowa Code section 50.19.

22.43(3) Test deck submitted by observers. Any person who is present at the public test may mark ballots to be used to test the voting equipment. The following conditions apply:

a. Not more than ten ballots may be submitted by any person.

b. Only official ballots provided by the commissioner at the test shall be used.

c. The observer submitting the test shall provide a written tally of the test deck.

d. The results of the machine tabulation shall be printed and compared with the observer's tally. If there are differences, the cause of the discrepancy shall be determined. If the cause of the discrepancy cannot be determined and corrected, the program or equipment shall not be used at the election.

e. The test decks, the tally, and the printed results of the test shall be kept with the records of the election and preserved as required by Iowa Code section 50.19.

Rules 721—22.41(52) through 721—22.43(52) are intended to implement Iowa Code section 52.35.

721—22.44 to **22.49** Reserved.

721—22.50(52) Voting system security. Each county shall have a written security policy. The policy shall include detailed plans to protect the election equipment and data from unauthorized access. The policy shall describe the methods to be used to preserve the integrity of the election and to document the election process.

22.50(1) *Staff access.* The security policy shall describe who shall have access to the voting equipment.

22.50(2) *Computers.* For security purposes, computers used in the commissioner's office to prepare ballots and voting equipment programs or to compile and report election results should not be used for any other function and should not be linked to any computer network or to the Internet.

a. If the election computers are linked to a network or to the Internet, the commissioner shall use a firewall to filter network traffic. Data transmissions over the Internet shall be encrypted and password-protected. Information posted to a Web site shall not be considered transmission of data over the Internet.

b. Access shall be limited to persons specified by the commissioner in the written security policy. The level of access shall be included in a written security policy.

(1) Uniqueness. Every ID and password shall be unique. The creation of generic or shared user IDs is specifically prohibited. Each user shall have exactly one user ID and password, except where job requirements necessitate the creation of multiple IDs to access different business functions.

(2) Authority. Each user shall be granted only the level of access specifically required by the user's job. Use of "Administrator," "Super User," "Security Administrator," or "SA" levels of authority shall be severely restricted.

(3) Generic user IDs. Staff members with generic user IDs are not allowed to sign on to voting systems.

(4) Password standards.

Account Policy	Recommended Setting
Maximum Password Age	90 days
Minimum Password Age	2 days
Minimum Password Length	8 characters
Enforced Password History	6 passwords (last 6 cannot be used)
Account Lockout (number of unsuccessful log-on attempts)	3 bad attempts
Account Lockout Duration	6 hours
Reset Account Lockout Counter After	6 hours

22.50(3) *Evacuation.* If it is necessary to evacuate the election office, a satellite absentee voting station or a polling place, the precinct election staff or the election officials shall immediately attempt to notify the commissioner and take the following actions:

a. Keep people safe.

b. If possible, gather and secure voted ballots, election equipment and critical election documents.

721—22.51(52) Memory cards. A memory card is a small, removable device containing data files of the election definition programmed for use in voting equipment for each election. For all voting equipment, the following security measures are required:

22.51(1) *Serial number.* Each memory card shall have a serial number printed on a readily visible label. The label shall include the name of the county.

22.51(2) *Inventory.* Memory cards owned by the county and retained in the custody of the county commissioner shall be maintained under perpetual inventory, with a record of inventory activity. The commissioner shall maintain a similar record of relevant actions if the memory cards are acquired from a vendor for each election. The record of inventory activity shall reflect:

a. The date each memory card was acquired;

b. Each use of each memory card in an election;

c. Each maintenance activity to a memory card, such as changing the battery;

d. Any problems or errors detected while using the memory card during its life;

e. Records of the disposal of any memory cards at the end of their useful life or upon return to the vendor for maintenance or warranty claims.

22.51(3) *Custody.*

a. In counties where the commissioner has the necessary software and equipment to program the memory cards locally, the commissioner shall maintain a memory card log for each election as required in subrule 22.51(4) during the period when the memory cards are removed from storage, prepared for an election, and until they are sealed into a voting device. Only county employees and precinct election officials, as applicable, authorized by the county's security policy shall be permitted to handle the memory cards. No one individual should be alone with the unsecured memory cards at any time. If a person who is not authorized by the security policy to have access to the memory cards transports them to another location, such as a warehouse, the memory cards shall be enclosed in a transport container with a tamper-evident seal.

b. In counties where the commissioner purchases programming services from a vendor, the memory cards shall be shipped to and from the vendor by a shipping service that employs tracking numbers. The memory cards shall be enclosed in a package sealed with a numbered, tamper-evident seal. Programmed memory cards shall be shipped in a package sealed with a numbered, tamper-evident seal from the vendor to the commissioner. If the seal is not intact upon arrival, the commissioner shall immediately contact the vendor for replacement cards. Only county employees authorized by the county's security policy (and precinct election officials, as applicable) shall be permitted to handle the memory cards. No one individual should be alone with the unsecured memory cards at any time.

22.51(4) *Memory card log.* For each election, the commissioner shall create a log to record the serial numbers of each memory card, the voting device into which the memory card was installed, the serial number of the seal, the ballot style and the precinct to which the machine is assigned. The log shall be in substantially the same form as Form A or Form B, as applicable:

Form A

State of Iowa

Election Log: Memory Cards for _____ County

Use this form in counties where the memory cards are programmed locally.

Memory card chain of custody record for: _____ Election to be held ___/___/20___

Memory Card Serial #	Precinct and/or Polling Place	Programmed By		Installed in Machine #	Installed By	Installation		Seal Number	Card Returned from Polls	
		Date	Time			Date	Time		By	Date

Memory Card Serial #	Precinct and/or Polling Place	Programmed By		Installed in Machine #	Installed By	Installation		Seal Number	Card Returned from Polls	
		Date	Time			Date	Time		By	Date

Form B*

State of Iowa

Election Log: Memory Cards for _____ County

Use this form if a vendor programs the memory cards.

Memory card chain of custody record for: _____ Election to be held ___/___/20___

Memory Card Serial #	Precinct and/or Polling Place	Sent for Programming		Installed in Machine #	Installed By	Installation		Seal Number	Card Returned from Polls	
		Date Out	Date In			Date	Time		By	Date

*Form B continues on next page.

Form B (cont'd)

Memory Card Shipping Record for _____ County

Shipped for programming:

Record each card number before packing to ship, and check out each card number on the chain of custody record. Enclose a photocopy of the Memory Card Record with the cards.

Shipped by: _____ _____ Date: ___/___/___ Time: ___:___a.m./p.m.
Print name Signature

Shipped to: _____ Shipped via: _____
_____ Tracking number: _____
_____

Instructions to vendor:

Check in each card number on the enclosed chain of custody record when unpacking cards.

By: _____ _____ Date: ___/___/___ Time: ___:___ a.m./p.m.
Print name Signature

- If memory cards are removed from this inventory for any reason, make a notation of which card(s) on the Memory Card Record.
- Replacement card(s) if issued should be added to the bottom of the Memory Card Record as a new card. A serial number will be assigned later by the receiving county.

Shipped via: _____ Date: _____ Tracking number: _____

Received by County Election Department on Date: ___/___/___

Was the package sealed? _____Was the seal intact? _____Notes: _____

Keep the memory cards in secure storage after they are received and until they are installed in the voting equipment.

22.51(5) *Preparation and installation.* When memory cards are installed, they shall be sealed immediately into the machine using a numbered, tamper-evident seal. Appropriate log entries shall be completed.

22.51(6) *Replacing seals or memory cards.* If a seal is accidentally broken or a memory card is replaced for any reason, the issuance of a new seal and the entry into the log shall be witnessed by more than one person. The facts of the incident and the names of the individuals who detected and resolved it shall be recorded.

22.51(7) *Opening the polls.* Immediately before the polls open on election day, the precinct election officials shall turn on the voting equipment and print the report showing that all counters are set at zero.

22.51(8) *Verification log.* The commissioner shall provide to each precinct a precinct verification log with the ballot record and receipt. The verification log shall provide places for precinct election officials to record or check the following information before the polls open and again before leaving the polling place at the end of the day:

a. Seal numbers from the voting equipment; and

b. Condition of seals on ballot containers.

22.51(9) *Election day.*

a. Before the polls are opened, the precinct election officials shall verify the required information in the verification log and sign the log.

b. After the polls are closed, the precinct election officials shall verify the required information in the verification log and sign the log before leaving the polling place.

c. If the precinct election officials remove the memory cards from the voting equipment, the officials shall first print the results report from the voting equipment.

22.51(10) *Return of memory cards.* If the precinct election officials remove the memory cards from the voting equipment on election night, they shall return to the commissioner the memory cards and the seals used to secure them in a sealed envelope or other container. All officials of the precinct shall witness the statement on the envelope or other container. The label on the envelope or other container shall be in substantially the following form:

Memory Cards

Election Date: _____
Precinct: _____

This envelope contains Memory Cards and memory card access seals from this precinct.

Machine Number	Memory Card #	Memory Card Seal #

[Signatures of all precinct election officials shall be included on the label.]

22.51(11) *Storage.* If the memory cards are returned inside the voting equipment to the commissioner, the machine serial numbers and the seal numbers shall be verified against the verification log described in subrule 22.51(8). When the memory cards are removed, their serial numbers shall also be verified against the verification log returned by the precinct's election officials. The memory card audit log shall be retained for the time period required by Iowa Code section 50.19.

22.51(12) *Results verified.* Before the conclusion of the canvass of votes, the individual results reports from the precincts, as signed by the precinct election officials at the polls on election night, shall be compared to the election results compiled for the canvass (either manually or electronically) to verify that transmitted and accumulated totals match the results witnessed by the election officials. Any discrepancies in these totals shall be reconciled before the supervisors conclude the canvass.

22.51(13) *Retention of programmed memory cards.* The election information on all memory cards used for an election shall be retained on the memory cards until after the time to file requests for recounts and election contests has passed. If a contest is pending, the memory cards shall be retained until the contest is resolved. Before the memory cards are permanently erased, the commissioner shall print the memory card audit log from each card.

22.51(14) *Retention of program information.* The commissioner shall retain all instructions and other written records of the process for programming the memory cards and the memory card audit logs for the period required by Iowa Code section 50.19. The contents of memory cards and other electronic records of the election process shall be collected and retained in an electronic or other medium and stored with the other election records for the time period required by Iowa Code section 50.19.

721—22.52(52) Voting equipment malfunction at the polls. The precinct election officials shall immediately cease using any malfunctioning voting equipment and report the problem to the commissioner. Only a person who is authorized in writing by the commissioner to do so shall be

permitted to attempt to repair malfunctioning voting equipment. The person shall show identification to the precinct election official. The commissioner shall keep a written record of all known malfunctions and their resolution. The precinct election officials shall return the voting equipment to service only if the malfunction is corrected.

22.52(1) *Routine resolution.* Some problems may be easily resolved by following simple instructions. If the commissioner and the precinct election officials are able to resolve a problem without replacing the equipment, the officials shall document the problem, the time it occurred, how it was resolved, and by whom.

22.52(2) *Repair or replacement.* Repairs to voting equipment at the polls on election day shall be limited. If the problem cannot be easily resolved, a person who is authorized to do so by the commissioner shall replace the equipment as soon as possible. Two election officials, one from each political party, shall witness repair or replacement of any voting equipment, including memory cards. The authorized person making the repair or replacement and the two election officials shall sign a report of the incident.

721—22.53 to **22.99** Reserved.

OPTICAL SCAN VOTING SYSTEMS

721—22.100(52) Optical scan ballots, automatic tabulating equipment, and absentee voting. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.101(52) Definitions. The definitions established by this rule shall apply whenever the terms defined appear in relation to an optical scan system used with the type of ballot defined in this rule.

"Ballot" means the official document that includes all of the offices or public measures to be voted upon at a single election, whether they appear on one or more optical scan ballots.

"Optical scan voting system" means a system employing optical scan ballots under which votes are cast by voters by marking the optical scan ballots with a ballot marking device and thereafter counted by use of automatic tabulating equipment.

"Overvote" means to vote for more than the permitted number of choices for any office or question on a ballot.

"Secrecy envelope" means a reusable envelope of sufficient construction that when the optical scan ballot is inserted in it all portions indicating voting marks are hidden from view.

"Tabulating device" means the portable apparatus which examines and counts the votes recorded on the optical scan ballot and produces a paper printout of the results of the voting.

"Ticket" means each list of candidates nominated by a political party or group of petitioners.

"Undervote" means to vote for fewer than the permitted number of choices for any office or question on a ballot.

"Voting system" means the total combination of mechanical, electromechanical or electronic equipment (including the software, firmware and documentation required to program, control and support the equipment that is used to define ballots, to cast and count votes, to report or display election results and to maintain and produce any audit trail information). "Voting system" also includes the practices and associated documentation used to identify system components and versions of such components, to test the system during its development and maintenance, to maintain records of system errors and defects, to determine specific system changes to be made to a system after the initial qualification of the system and to make available any materials to the voter such as notices, instructions, forms or paper ballots. (See Section 301(b) of HAVA.)

"Voting target" means the space on an optical scan ballot which the voter marks to cast a vote for a candidate, judge or question. This target shall be printed according to the requirements of the voting system to be used to read the ballots.

721—22.102(52) Optical scan ballots. The optical scan ballots shall be printed pursuant to Iowa Code chapters 43 and 49 and by any relevant provisions of any statutes which specify the form of ballots for special elections, so far as possible within the constraints of the physical characteristics of the system.

22.102(1) The optical scan ballots may be printed on both sides of a sheet of paper. If both sides are used, the words "Turn the ballot over" shall be clearly printed on the front and the back of the optical scan ballot, at the bottom.

22.102(2) Printed at the top of the front side of the optical scan ballot shall be the name and date of the election; the words "Official Ballot"; a designation of the ballot style or precinct, if any; and a facsimile of the commissioner's signature.

22.102(3) The voting target shall be printed opposite each candidate's name and write-in line on the optical scan ballot, and opposite the "yes" and "no" for each public measure and judge. The voting target shall be printed on the left side of the name or "yes" and "no". The voting target shall be an oval unless the voting system requires a target with a different shape.

22.102(4) For partisan primary elections, the names of candidates representing each political party shall be printed on separate optical scan ballots. The ballots shall be uniform in quality, texture and size. The name of the political party shall be printed in at least 24-point type (¼″ high) at the top of the ballot.

22.102(5) There shall be printed on the ballot a line to accommodate the initials of the precinct election official who endorses the ballot as provided in Iowa Code sections 43.36 and 49.82.

22.102(6) It is not necessary for public measures to be printed on colored paper.

22.102(7) Ballots shall be coded as necessary to allow the tabulation program to identify the appropriate ballots for the precinct. Ballots shall be coded so the tabulating device can identify by precinct the votes cast for each office and question on the ballot by precinct. The votes from the absentee and special voters precinct shall be reported as a single precinct except in general elections pursuant to Iowa Code section 53.20 as amended by 2008 Iowa Acts, House File 2367. Identical ballots shall not be coded to identify groups of voters within a precinct.

22.102(8) No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot. If the full text of a public measure will not fit on a single column of the ballot, the commissioner shall prepare a summary for the ballot and post the full text in the voting booth as required by Iowa Code section 52.25.

22.102(9) Ballots shall be stored in a locked room or storage area. Access to the storage area shall be restricted to those persons identified in the election security plan. Throughout the election process, the commissioner shall keep accurate records of the number of each type of ballot or ballot style printed for the election. This record shall include the number of ballots:

a. Ordered from the printer.

b. Printed and delivered by the printer to the commissioner. The commissioner may store sealed, unopened packages of ballots without verifying the number of ballots in the package.

c. Used for testing as required by Iowa Code sections 52.9 and 52.35 and rule 721—22.41(52).

d. Held in reserve for emergencies as required by Iowa Code section 49.66.

e. Delivered to and returned from the polling places as required by Iowa Code sections 49.65 and 50.10.

f. Used for absentee voting, including any spoiled ballots.

g. Issued as sample ballots to the public as permitted by Iowa Code section 43.30.

h. Photocopied ballots used pursuant to Iowa Code section 49.67.

i. Printed by the commissioner using any voting system program, such as Election Systems & Software's Ballot on Demand program.

721—22.103 to **22.199** Reserved.

PRECINCT COUNT SYSTEMS

721—22.200(52) Security.

22.200(1) At least one tabulating device shall be provided at each precinct polling place for an election. If the tabulating device is delivered to the polling place before election day, it shall be secured against tampering or kept in a locked room.

22.200(2) The maintenance key or keys used to gain access to the internal parts of the tabulating device shall be kept in a secure place and in a secure manner, in the custody of the commissioner. On election day, the key used to obtain the paper printout shall be kept by the chairperson of the precinct election officials in a secure manner. Small electronic devices, such as memory cards, cartridges or other data storage devices used to activate tabulation equipment or to store election information, shall be in the custody of the precinct chairperson when the devices are not installed on the voting equipment.

22.200(3) If a password is needed for precinct election officials to have routine access to the tabulating device during election day, the password shall be changed for every election. The commissioner shall restrict access to the password in the written security policy.

721—22.201(52) Programming and testing the tabulating devices for precinct count systems.

22.201(1) All programming of tabulating devices shall be performed under the supervision of the commissioner. The devices shall be programmed to ensure that all votes will be counted in accordance with the laws of Iowa. Tabulating devices shall be programmed to return to the voter any ballots:

a. That are not coded to be used in the precinct.

b. That are read as blank.

c. That have one or more overvoted offices or public measures.

22.201(2) Rescinded IAB 10/25/06, effective 10/4/06.

721—22.202(50) Unique race and candidate ID numbers for election night results reporting. All tabulating devices programmed for primary and general elections and for special elections conducted pursuant to Iowa Code section 69.14 shall be programmed using the unique race and candidate ID numbers assigned by the state commissioner. The unique race and candidate ID numbers will be provided to the county commissioners with the candidate certification prepared by the state commissioner.

This rule is intended to implement Iowa Code chapter 50.

[**ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—22.203(50) Reporting election night results electronically. For all primary and general elections, the county commissioner shall provide the state commissioner with an electronic results file generated from the county's vote tabulation software system, if any. For special elections conducted pursuant to Iowa Code section 69.14, the county commissioner shall provide election night results in the manner requested by the state commissioner.

This rule is intended to implement Iowa Code chapter 50.

[**ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—22.204 to **22.220** Reserved.

721—22.221(52) Sample ballots and instructions to voters. Sample special paper ballots and printed instructions for casting votes on special paper ballots shall be prominently displayed in each polling place. Instructions shall also be displayed inside each voting booth. Each special paper ballot shall also include an example of the method of marking the ballot recommended by the manufacturer of the tabulating device. Further instructions shall be provided to any voter who requests assistance in accordance with Iowa Code section 49.90.

721—22.222 to **22.230** Reserved.

721—22.231(52) Emergency ballot box or bin. Each precinct shall be furnished with an emergency ballot box or bin that is suitably equipped with a lock and key or numbered, tamperproof seal. In the event of power failure or malfunction of the tabulating device, voted ballots shall be deposited in the locked or sealed emergency ballot box or bin. A precinct election official shall put the ballot into the emergency ballot box or bin for the voter. The voted ballots so deposited may be removed from the locked emergency ballot box or bin and tabulated before the polls close whenever a properly functioning tabulating device becomes available, or the voted ballots so deposited may be removed and counted

electronically or manually immediately after the polls are closed. If the ballots are counted manually, the precinct election officials shall follow the requirements of 721—Chapter 26.

721—22.232(52) Manner of voting. After the precinct election official has endorsed a ballot, the official shall instruct the voter to use only the marker provided. The ballot shall be inserted in a secrecy folder and given to the person who is entitled to receive the ballot in accordance with the provisions of Iowa Code section 49.77.

22.232(1) The precinct officials shall provide each voter with a secrecy folder. The commissioner may print basic ballot marking instructions on the secrecy folder. It is not necessary to print information on secrecy folders that will limit the usefulness of the secrecy folder to one or more elections or election types. Upon receipt of the ballot in the secrecy folder, the voter shall retire alone to a voting booth and without delay mark the ballot.

22.232(2) The voter shall vote upon the ballot by marking the appropriate voting target with an appropriate pen or pencil in the manner described in the instructions printed on the ballot.

When a write-in vote has been cast, the ballot must also be marked in the corresponding voting target in order to be counted.

22.232(3) After marking the ballot, the voter shall replace it in the secrecy folder and leave the voting booth at once.

22.232(4) The voter shall at once deposit the ballot, still enclosed in the secrecy folder, in the tabulating device so that the ballot is automatically removed from the secrecy folder, the votes tabulated, and the ballot deposited in the ballot box.

22.232(5) If the tabulating device is equipped with a mechanism that will not permit more than one ballot to be inserted at one time, the voter may insert the ballot into the tabulating device. If the tabulating device cannot detect and reject multiple ballots, the voter shall be required to hand the ballot in the secrecy folder to the precinct election official without revealing any of the marks on the ballot. The precinct election official shall at once deposit the ballot in the manner described in subrule 22.232(4).

22.232(6) If the tabulating device returns a ballot, the precinct official attending the device shall ask the voter to wait. Without examining the ballot, the official shall enclose the returned ballot in a secrecy folder. If necessary, the official shall read to the voter the information provided by the device about the reason the ballot was returned. The official shall offer the voter the opportunity to correct the ballot. The precinct official shall mark the returned ballot "spoiled" and shall also tear or mark the ballot so that the tabulating device cannot count it. The voter may use the spoiled ballot as a guide for marking the corrected ballot. After the voter has marked the corrected ballot, the precinct officials shall collect the spoiled ballot and keep it with other spoiled ballots.

22.232(7) If the voter who cast the returned ballot is not available, or declines to correct the ballot, the precinct official shall not mark the ballot "spoiled." Either the voter or the official shall reset the tabulating device to accept the ballot. The voter, or the official if the voter has gone, shall insert the ballot into the precinct counter without further examination.

721—22.233 to **22.239** Reserved.

721—22.240(52) Results. After the polls are closed and the tabulating device has processed all of the ballots, including any ballots from the emergency ballot box or bin, the precinct election officials shall:

22.240(1) Unlock the tabulating device and obtain a paper printout showing the votes cast for each candidate and public measure.

22.240(2) Fasten the paper printout to the official tally sheet.

22.240(3) Unlock or remove the seal on the ballot box or bin containing ballots with write-in votes and open it. The precinct officials shall remove the ballots and manually count the write-in votes as required by 721—Chapter 26. The officials shall record the write-in votes in the tally list. A single tally list is sufficient for use when tabulating write-in votes.

22.240(4) Seal all ballots in a transfer case to be returned to the commissioner in accordance with Iowa Code section 50.12.

22.240(5) It is not necessary for the precinct officials to separate primary election ballots by political party.

721—22.241(52) Electronic transmission of election results. If the equipment includes a modem for the electronic transmission of election results, the precinct officials may transmit the results after a printed copy has been made. If the voting system includes a data card, cartridge or other small device that contains an electronic copy of the election results, the precinct chairperson shall secure the device and ensure its safe delivery to the commissioner.

721—22.242 to **22.249** Reserved.

721—22.250(52) Absentee voting instructions. Printed instructions shall be included with the ballot or ballots given to or mailed to each absentee voter. Written instructions to the voter shall be sent with every absentee ballot. For federal elections, the commissioner shall use only the instructions provided by the state commissioner.

721—22.251(52) Absentee voting instructions. Rescinded IAB 11/23/05, effective 12/28/05.

721—22.252 to **22.259** Reserved.

721—22.260(52) Specific precinct count systems. Additional rules are provided for the following systems approved for use in Iowa. Rule 721—22.261(52) applies only to the voting system indicated and is in addition to the general provisions set forth in rules 721—22.200(52) through 721—22.250(52).

721—22.261(52) Election Systems & Software Model 100—preparation and use in elections.

22.261(1) *Security.* The commissioner shall have a written security plan for the voting system. Access to equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

a. Passwords used at the polling places on election day shall be changed for each election.

b. The control key for the Model 100 shall be in the possession of the precinct chairperson during election day.

22.261(2) *Configuration choices.* The following selections are mandatory for all elections:

a. Maximum number of votes. The following description for each office shall be used: "Vote for no more than xx." Do not include "vote for" language for public measures or judges.

b. Ballot control. In an official election, the commissioner shall never program the Model 100 for unconditional acceptance of all ballots; shall not divert blank ballots to the write-in bin; and shall always accept undervoted ballots. The system shall be programmed to query the voter in each of the following situations:

(1) Overvoted ballot.

(2) Blank ballot.

(3) Unreadable ballot.

c. Unit control. The commissioner shall not select automatic transmission of election results by modem. The precinct officials must print the official results at the polling place before transmitting them.

d. Reports. The following are required reports:

(1) Opening the polls. Print the Zero Certification report.

(2) Closing the polls. Print the poll report before transmitting the election results by modem. The poll report is the official record of the votes cast in the precinct on election day.

(3) Certification text to appear at the end of the poll report:

We, the undersigned Precinct Election Officials of this precinct, hereby attest that this tape shows the results of all ballots cast and counted by the M100 Optical Scan tabulation device at this election.

[print lines for each of the officials to sign]

Precinct Election Officials Date: _____ Time: _____

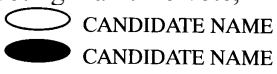
e. Reopen polls. The commissioner shall enable this option, but protect it against unauthorized use. If it is necessary to reopen the polls, the chairperson of the precinct board shall contact the commissioner for the password.

22.261(3) *Ballot printing.*

a. Format. The office title, instructions about the maximum number of choices the voter can make for the office, the candidate names and all write-in lines associated with each office on the ballot shall be printed in a single column on the same side of the ballot. All text and the "yes" and "no" choices for each public measure and for each individual judge on a ballot shall be printed in a single column on the same side of the ballot. No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot.

b. Instructions for voters. The following instructions shall be printed on ballots:

(1) Voting mark. To vote, fill in the oval next to your choice.



(2) Straight party voting. To vote for all candidates from a single party, fill in the oval in front of the party name. Not all parties have nominated candidates for all offices. Marking a straight party vote does not include votes for nonpartisan offices, judges or questions.

(3) Public measures.

Notice to voters. To vote to approve any question on this ballot, fill in the oval in front of the word "Yes". To vote against a question, fill in the oval in front of the word "No".

22.261(4) *System error messages.* Precinct election officials shall be provided with the following list of system error messages and the appropriate responses. The officials shall be instructed to contact the commissioner or the commissioner's designee for all other messages.

Overvoted ballot returned. Ask voter to reinsert ballot. If the ballot is returned again, do not look at the voter's ballot. Put it in a secrecy folder. Tell the voter that for one or more offices the scanner read more votes than the maximum number of votes allowed. To correct the error, the voter must mark a new ballot and may copy votes from the original ballot. Only if the voter agrees to mark a new ballot, write "spoiled" on the original ballot and tear off one corner to prevent it from being accepted by the scanner. Advise the voter to return to the booth and mark the new ballot. Be sure to collect the spoiled ballot before the voter leaves.

Overvoted ballot accepted. This message will appear when the scanner accepts an overvoted ballot.

Unidentified mark—check your ballot. One or more marks on the ballot are not dark enough to be seen as a vote. Do not look at the voter's ballot. Put it in a secrecy folder and return the ballot to the voter. Ask the voter to review the ballot and to darken the marks. Then the voter may put the ballot back into the scanner.

If any of the following messages appear more than twice for the same ballot, call the auditor's office to report the problem:

100—MISSED ORIENTATION MARKS/Turn Ballot Over and Try Again.
101—MISSED TIMING MARKS/Turn Ballot Over and Try Again.
102—NO DATA FOUND/Please Reinsert Ballot After Beeps.
104—ORIENTATION SKIP ERROR.
106—MISSED TIMING MARKS/Turn Ballot Over and Try Again.

If any of the following messages appear, ask the voter to remove the ballot and reinsert it. If the same message appears more than twice for the same ballot, call the auditor's office to report the problem.

107—BALLOT ERROR: INVALID CC SEQUENCE.
108—BALLOT ERROR: INVALID CC TYPE.
109—BALLOT ERROR: INVALID CC SPLIT.
115—MISSED BACK ORIENTATION MARK/Turn Ballot Over and Try Again.
119—MULTIPLE BALLOTS DETECTED/Please Reinsert Ballot After Beeps. Did the voter actually try to put an extra ballot in? Is the ballot folded?
123—UNABLE TO READ TIMING BAND/Turn Ballot Over and Try Again.
124—BALLOT DRAGGED/Turn Ballot Over and Try Again.

126—BLACK CHECK: FACE DOWN HEAD EDGE/Turn Ballot Over and Try Again.
127—BLACK CHECK: FACE DOWN TAIL EDGE/Turn Ballot Over and Try Again.
128—BLACK CHECK: FACE UP HEAD EDGE/Turn Ballot Over and Try Again.
129—BLACK CHECK: FACE UP TAIL EDGE/Turn Ballot Over and Try Again.
130—POSSIBLE FOLDED BALLOT/Turn Ballot Over and Try Again.

22.261(5) *Record retention.* The Model 100 uses a thermal printer. The maximum anticipated life span of the results from each Model 100 is only five years. In order to preserve the permanent record of the precinct results required by Iowa Code section 50.19, the commissioner shall print a copy of the results of each precinct on permanent paper and store these copies with the tally lists from precincts where the Model 100 was used.

[**ARC 9468B**, IAB 4/20/11, effective 5/25/11]

721—22.262(52) Premier Election Solutions' AccuVote OS and AccuVote OSX precinct count devices.

22.262(1) *Security.* The commissioner shall have a written security plan for the voting system. Access to voting equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

a. Passwords used at polling places shall be changed for each election.

b. For each election, the precinct chairperson shall be responsible for the custody and security of the control card and ballot box keys and the security of the voting system.

22.262(2) *Configuration choices.* The following selections are mandatory for all elections:

a. Reject settings shall be configured as follows:

(1) Return to voters ballots that include one or more overvoted races and blank-voted ballots. Include on the override log the number of times the override option was used for overvoted and blank-voted ballots.

(2) Divert to the write-in ballot bin only ballots with write-in votes.

(3) Do not include reject settings for blank voted races, undervoted races, straight party overvotes, multiparty overvotes or duplicate votes.

b. Tally settings shall be as follows:

(1) The straight party shall be "Exclusive."

(2) The write-in setting shall be "Combined."

22.262(3) *Zero totals reports.* Long form zero totals reports showing all counters at zero shall be printed following memory card programming, before counting ballots in the Pre-Election Mode and as the ballot reader is opened on election day.

22.262(4) *Ballot printing.* Although the Premier Election Solutions' GEMS voting system software includes choices for variations in ballot layout, all ballots shall be prepared according to the requirements of Iowa Code sections 43.26 through 43.29 and 49.30 through 49.48. For all elections the voting target shall be an oval printed on the left side of each choice on the ballot.

22.262(5) *Preelection testing.* All voting equipment shall be tested pursuant to the provisions of Iowa Code section 52.30 and rule 721—22.42(52). At the commissioner's discretion, the commissioner may conduct additional tests.

721—22.263(52) AutoMARK Voter Assist Terminal (VAT).

22.263(1) *Acceptance testing.* Upon receipt of the equipment from the vendor, the commissioner shall subject each AutoMARK VAT to an acceptance test. The test shall be in addition to any testing provided by the vendor and shall include a demonstration of all functionalities of the device.

22.263(2) *Audio ballot preparation.* Each candidate shall have the opportunity to provide a record of the proper pronunciation of the candidate's name. The same voice shall be used for recording the entire ballot including instructions, office titles, candidate names and the full text of all public measures.

22.263(3) *Preelection testing.* Each AutoMARK VAT shall be tested before each election in which it will be used. The commissioner may use the AutoMARK VAT to prepare some ballots for test decks required by rule 721—22.42(52). In addition, the commissioner shall:

a. Perform the test ballot print, then review the ballot to be sure that all ovals are darkened and the appropriate names are printed on each line.

b. Calibrate the touchscreen.

c. Select, then deselect each voting position in each race.

d. Verify that the overvote and undervote functions are programmed correctly.

e. Test the write-in function for each office on one ballot, and test all of the letters in the alphabet.

f. Use the audio ballot function to mark one ballot.

g. Tabulate the marked ballots from this test on the appropriate optical scanner.

h. Ensure that the AutoMARK VAT is available for demonstration at public tests.

22.263(4) *Compact flash memory cartridge or memory card.* The compact flash memory cartridge shall be installed before the AutoMARK VAT is locked, sealed and shipped to the polling place for election day. In addition to locking the memory cartridge access door, the commissioner shall seal the door with a numbered seal, record the seal number, and provide the number to the precinct election officials as required by rule 721—22.51(52). From the time the AutoMARK VAT is delivered to the polling place until the time the precinct election officials arrive, the AutoMARK VAT shall be stored securely to prevent tampering. On election day, the precinct election officials shall inspect the seal and verify that the original numbered seal is present and undamaged.

22.263(5) *Calibration testing.* The commissioner may provide for printer and touchscreen calibration testing after delivery of the AutoMARK VAT to the polling place. If calibration testing is performed at the polling place, the delivery staff shall complete the testing before the polls open on election day and shall keep a log for each AutoMARK VAT and record the machine serial number, the precinct name or number, the date and time of the test, the name of the person performing the test, and the lifetime printer counter number at the completion of the test. The ballot to be used in the calibration test shall be provided to the tester and shall be labeled with the precinct name and election date. The completed calibration test ballot shall be returned to the commissioner and kept with the election records.

22.263(6) *AutoMARK VAT keys.* Possession of the AutoMARK VAT keys shall be restricted to precinct election officials and authorized members of the commissioner's staff.

22.263(7) *Table.* The table used to support the AutoMARK VAT shall meet the following requirements: The table shall be sturdy enough to hold the 40-pound AutoMARK VAT safely. Clearance shall be at least 27 inches high, 30 inches wide, and 26 inches deep. The top of the table shall be from 28 inches to 34 inches above the floor.

22.263(8) *Privacy.* The commissioner may provide each AutoMARK VAT with a privacy shield to protect the secrecy of each voter's ballot. The commissioner shall instruct the precinct election officials to position the AutoMARK VAT to provide maximum access for voters (especially voters who use wheelchairs) as well as privacy.

22.263(9) *Abandoned ballots.* If a voter or precinct election official discovers that a voter has left the AutoMARK VAT without printing the voter's ballot, the two precinct election officials designated to assist voters shall print the ballot without reviewing the ballot or making any changes, enclose the ballot in a secrecy folder, and immediately deposit the ballot in the tabulating device.

721—22.264 to **22.339** Reserved.

OPTICAL SCAN VOTING SYSTEM USED FOR ABSENTEE AND SPECIAL VOTERS PRECINCT

721—22.340(52) Processing. All scanners used to tabulate absentee and provisional ballots shall be configured to sort blank ballots and ballots containing marks in write-in vote targets for review by the resolution board. The scanners shall not be configured to sort ballots with overvotes. However, if it is not possible to configure the scanners used to count absentee ballots differently from those used at the polling places, the person operating the scanner shall override the scanner and accept overvoted ballots

as they are processed. The resolution board shall follow the requirements of 721—subrule 26.2(2). The commissioner shall provide the resolution board with a copy of 721—Chapter 26, "Counting Votes."

This rule is intended to implement Iowa Code section 52.33 as amended by 2007 Iowa Acts, Senate File 369, section 9.

721—22.341(52) Reporting results from absentee ballots and provisional ballots. Absentee and provisional ballot results shall be reported as a single precinct as required by subrule 22.102(7).

721—22.342(52) Tally list for absentee and special voters precinct.

22.342(1) Write-in votes shall be reported on a separate tally sheet which provides a column for the names of offices, a column for the names of persons receiving votes, space to tally the votes received, and a column in which to report the total number of votes cast for each person. In tally lists provided for primary elections, separate pages shall be provided to tally the write-in votes for each political party. Each member of the board who participated in the count shall attest to each tally sheet for write-in votes.

22.342(2) The officials shall certify the procedures followed. The certification shall be in substantially the following form:

Absentee and Special Voters Tally Certificate

_____County

We, the undersigned officials of the Absentee and Special Voters Precinct for this county, do hereby certify that all ballots delivered to the Board for this election were tabulated as shown in the attached report.

We further certify that a record of any write-in votes or other votes manually counted pursuant to Iowa Code chapter 52 is included in this Tally List, and that the numbers entered in the column headed "Total Votes" are the correct totals of all votes manually counted by us.

Signed at _____ on ____/____/____, ___:___ a.m./p.m.

[signatures of officials] 1. _____

2. _____ (etc.)

22.342(3) The record generated by the tabulating equipment shall be attached to or enclosed with the tally list and shall constitute the official return of the precinct.

This rule is intended to implement Iowa Code section 52.33 as amended by 2007 Iowa Acts, Senate File 369, section 9.

721—22.343(39A,53) Counting absentee ballots on the day before the general election. When absentee ballots are tabulated on the day before the election as permitted or required by Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670, the absentee and special voters precinct board and county commissioner shall implement the following security precautions:

22.343(1) *Seal and label voted ballot envelopes or other containers with date of tabulation.* The precinct election officials shall seal all ballots tabulated on the day before the election in a voted ballot envelope or other container labeled with the date of tabulation. The precinct election officials shall seal and sign the envelope or other container in a manner that will make it evident if the envelope or other container is opened.

22.343(2) *Ensure secure storage of all ballots.* Before adjourning for the day, the precinct election officials shall transfer custody of all absentee ballots to the commissioner. The commissioner shall ensure all absentee ballots are stored in a secure location until tabulation is resumed on election day.

22.343(3) *Ensure memory card security.* Before the absentee and special voters precinct board adjourns for the day, the memory card used in the tabulator(s) on the day before the election shall be secured by the precinct election officials in one of the following ways:

a. The memory card may be left in the tabulator when a tamper-evident seal is affixed over the memory card in a manner that will make it evident if the seal is removed.

b. The memory card may be removed from the tabulator and placed in an envelope. The precinct election officials shall seal the envelope in a manner that will make it evident if the envelope is opened.

22.343(4) *Ensure security of the tabulator(s).* Before adjourning for the day, the precinct election officials shall ensure the security of the tabulator(s). The tabulator(s) must be stored in a secure location until the absentee and special voters precinct board resumes tabulation on election day.

22.343(5) *No results tape printing on the day before the election.* No results tapes may be printed from the tabulator(s) on the day before the election.

22.343(6) *No upload of results to tabulating software until election day.* No results may be uploaded or input into tabulating software on the day before the election.

22.343(7) *Verify no tampering before resuming tabulation on election day.* Before tabulation resumes on election day, the absentee and special voters precinct board shall verify the tabulator(s), memory card(s) and memory card port(s) have not been obviously tampered with overnight.

22.343(8) *Resume tabulation.* The absentee and special voters precinct board shall resume tabulation using one of the following methods:

a. Using the same memory card(s) used on the day before the election and resuming tabulation.

b. Using a new memory card(s) and compiling the results contained on the memory card(s) used on election day and on the day before the election.

22.343(9) *Print audit logs.* After the election, the audit logs must be printed and be available for public inspection.

This rule is intended to implement Iowa Code section 39A.5, section 1, paragraph *"a,"* subparagraph (3), and Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670.
[**ARC 8698B**, IAB 4/21/10, effective 6/15/10]

721—22.344 to **22.349** Reserved.

721—22.350(52) Election Systems & Software models. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.351(52) Diebold Election Systems' AccuVote-OS central count process. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.352 to **22.430** Reserved.

VOTING MACHINES

721—22.431(52) Temporary use of printed ballots in voting machine precincts. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.432(52) Abandoned ballots. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.433(52) Prohibited uses for direct recording electronic voting machines. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.434(52) Audio ballot preparation. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.435 to **22.460** Reserved.

721—22.461(52) MicroVote Absentee Voting System. Rescinded IAB 8/1/07, effective 7/13/07.

721—22.462(52) Fidlar & Chambers' Absentee Voting System. Rescinded IAB 10/30/02, effective 1/1/03.

721—22.463(52) Election Systems & Software iVotronic. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.464(52) Diebold Election Systems AccuVote TSX DRE. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.465 to **22.499** Reserved.

721—22.500(52) Blended systems. Rescinded IAB 10/8/08, effective 9/19/08.

These rules are intended to implement Iowa Code chapter 52.

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CHAPTER 28
VOTER REGISTRATION FILE (I-VOTERS) MANAGEMENT

721—28.1(47,48A) State registrar's responsibility. The state registrar of voters is responsible for the implementation of a single, uniform, official, centralized, interactive, computerized statewide voter registration file of every legally registered voter in the state. This file is known as I-VOTERS. These rules regulate access to the file by county registrars and others and set forth protocols for adding, changing or deleting file information.

721—28.2(48A) Access and fees.

28.2(1) The state registrar and county registrars shall grant access to the I-VOTERS database consistent with the Iowa Code and the security plan for the system. Authorized users of the system shall be issued secure password-protected access that is monitored by the state registrar. Access may be denied or revoked by the state registrar for violation of the security policy.

28.2(2) Fees shall be assessed by the state registrar and county registrars for voter registration information provided to the public or to authorized requesters consistent with Iowa Code chapter 48A and the rules of the voter registration commission. The state registrar shall establish appropriate forms for voter registration information requests. Fees collected by the state registrar shall be deposited in the state general fund. Fees collected by county registrars shall be deposited in the appropriate county fund.

28.2(3) Statewide or congressional district voter registration information from I-VOTERS may be obtained only from the state registrar. Voter registration information from I-VOTERS other than statewide or congressional district information may be obtained from the state registrar or a county registrar. A county registrar may provide from I-VOTERS voter registration information for a district or other jurisdiction that is located in whole or in part within the registrar's county.

721—28.3(48A) Duplicate and multiple voter registration record deletion process.

28.3(1) The state registrar shall provide a search function within the I-VOTERS software to search for likely duplicate or multiple voter registration records. County registrars shall have the capability to activate this function.

28.3(2) During each calendar quarter, the county registrar shall activate the search function described in 28.3(1) and review the list of likely duplicate or multiple voter registration records. The county registrar shall resolve duplicate or multiple records for the same voter. No voter shall have more than one voter record. The voter record associated with the most recent registration or other voter-initiated activity shall be considered the voter's current record. The voter shall be registered in the county of current record, and the voter record in any other county shall be merged with the record in the current county. Individual voter history and other voter data shall be transferred to the voter's record in the current county of registration.

28.3(3) The state registrar shall periodically engage in interstate checking of voter registration records with cooperating states for the purpose of identifying duplicate or multiple voter registration records. A list of likely matches of records based upon predetermined search criteria shall be timely sent to each county registrar.

28.3(4) Within 15 days of the receipt of a list produced by the state registrar in accordance with 28.3(3), the county registrar shall review the list of likely duplicate or multiple voter registration records and determine the accuracy of the search results. If the voter is found to be registered to vote in another state more recently than in Iowa, the commissioner shall make the voter's status "inactive" and the voter shall be mailed a National Voter Registration Act-compliant confirmation notice. The notice shall contain a statement in substantially the following form:

> Information received by this office indicates that you are no longer a resident at the address printed on the reverse side of this card. If this information is not correct, and you still live at that address, please complete and mail the attached postage-paid card at least 10 days before the primary or general election, or at least 11 days before any other election at which you wish

to vote. If the information is correct and you have moved within the county, you may update your registration by listing your new address on the card and mailing it back. If you have moved outside the county, please contact a local official in your new location for assistance in registering there. If you do not mail in the card, you may be required to show identification before being allowed to vote in [name of county] County, Iowa. If you do not return the card and you do not vote in an election in [name of county] County, Iowa, on or before (date of second general election following the date of the notice), your name will be removed from the list of voters in that county.

28.3(5) County registrars shall cooperate with each other to ensure that voter records are properly merged into the current county file.

[**ARC 9989B**, IAB 2/8/12, effective 1/17/12]

721—28.4(48A) Cancellations and restorations of voter registration due to felony conviction.

28.4(1) Based upon information provided to the state registrar by the state or federal judicial branch and by the governor, the state registrar shall maintain a list of convicted felons and a list of convicted felons whose voting rights have been restored. Periodically, these lists shall be matched with I-VOTERS. Based upon predetermined search criteria, a list of likely matches of ineligible voters shall be produced for each county and provided to each county registrar.

28.4(2) Within 15 days of the receipt of the list produced by the state registrar in accordance with 28.4(1), the county registrar shall review the list of likely matches, determine the accuracy of the search results and cancel the registrations of those voters found to be ineligible to vote. Notice shall be sent to the voter at the voter's address in the voter registration file pursuant to Iowa Code section 48A.30(2). The notice shall provide the voter an opportunity to have the county registrar review any relevant information that establishes the voter's eligibility to vote. When inclusion of a voter's name on the list of likely matches is found to be inaccurate, the registrar shall mark the record as a "no match" and provide that information to the state registrar.

28.4(3) New applicants for registration entered into I-VOTERS by a county registrar shall be electronically matched against the list of convicted felons in the file, and applicants disqualified due to felony conviction shall not be registered as voters. The county registrar shall notify the registration applicant of the applicant's disqualification in the same manner as provided for in subrule 28.4(2) above.

These rules are intended to implement Iowa Code section 47.7(2) and chapter 48A.

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TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 634
DRIVER EDUCATION

CHAPTER 635
MOTORCYCLE RIDER EDUCATION (MRE)

CHAPTER 636
MOTORIZED BICYCLE RIDER EDUCATION

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DRIVER LICENSES

CHAPTER 600
GENERAL INFORMATION

[Prior to 6/3/87, Transportation Department[820]—(07,C)Ch 13]

761—600.1(321) Definitions. The definitions in Iowa Code section 321.1 and the following definitions apply to the rules in 761—Chapters 600 to 699.

"Director of the office of driver services" includes the office director's designee.

"License" means "driver's license" as defined in Iowa Code subsection 321.1(20A) unless the context otherwise requires.

"Medical report" means a report from a physician attesting to a person's physical or mental capability to operate a motor vehicle safely. The report should be submitted on Form 430031, "Medical Report." In lieu of Form 430031, a report signed by a physician on the physician's letterhead may be accepted if it contains all the information specified on Form 430031.

"Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery.

This rule is intended to implement Iowa Code section 321.1.

761—600.2(17A) Information and location. Applications, forms and information concerning driver's licensing are available at any driver's license examination station. Assistance is also available by mail from the Office of Driver Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (800)532-1121; or by facsimile at (515)237-3071.

This rule is intended to implement Iowa Code section 17A.3.

761—600.3(321) Persons exempt.

600.3(1) Persons listed in Iowa Code section 321.176 are exempt from driver's licensing requirements.

600.3(2) "Nearby" in Iowa Code subsection 321.176(2) shall mean a distance of not more than two miles.

This rule is intended to implement Iowa Code section 321.176.

761—600.4(252J,261,321) Persons not to be licensed.

600.4(1) The department shall not knowingly issue a license to any person who is ineligible for licensing.

600.4(2) The department shall not knowingly license any person who is unable to operate a motor vehicle safely because of physical or mental disability until that person has submitted a medical report stating that the person is physically and mentally capable of operating a vehicle safely.

600.4(3) The department shall not knowingly license any person who has been specifically adjudged incompetent, pursuant to Iowa Code chapter 229, on or after January 1, 1976, including anyone admitted to a mental health facility prior to that date and not released until after, until it receives specific adjudication that the person is competent. A medical report stating that the person is physically qualified to operate a motor vehicle safely shall also be required.

600.4(4) The department shall not knowingly license any person who suffers from syncope of any cause, any type of periodic or episodic loss of consciousness, or any paroxysmal disturbances of consciousness, including but not limited to epilepsy, until that person has not had an episode of loss of consciousness or loss of voluntary control for six months, and then only upon receipt of a medical report favorable toward licensing.

a. If a medical report indicates a pattern of only syncope, the department may license without a six-month episode-free period after favorable recommendation by the medical advisory board.

b. If a medical report indicates a pattern of such episodes only when the person is asleep or is sequestered for sleep, the department may license without a six-month episode-free period.

c. If an episode occurs when medications are withdrawn by a physician, but the person is episode-free when placed back on medications, the department may license without a six-month episode-free period with a favorable recommendation from a neurologist.

d. If a medical report indicates the person experienced a single nonrecurring episode, the cause has been identified, and the physician is not treating the person for the episode and believes it is unlikely to recur, the department may license without the six-month episode-free period with a favorable recommendation from a physician.

600.4(5) The department shall not license any person who must wear bioptic telescopic lenses to meet the visual acuity standard required for a license.

600.4(6) When a medical report is required, a license shall be issued only if the report indicates that the person is qualified to operate a motor vehicle safely. The department may submit the report to the medical advisory board for an additional opinion.

600.4(7) When the department receives evidence that an Iowa licensed driver has been adjudged incompetent or is not physically or mentally qualified to operate a motor vehicle safely, the department shall suspend the license for incapability, as explained in rule 761—615.14(321), or shall deny further licensing, as explained in rule 761—615.4(321).

600.4(8) The department shall not knowingly issue a license to a person who is the named individual on a certificate of noncompliance that has been received from the child support recovery unit, until the department receives a withdrawal of the certificate of noncompliance or unless an application has been filed pursuant to Iowa Code section 252J.9.

600.4(9) The department shall not knowingly issue a license to a person who is the named individual on a certificate of noncompliance that has been received from the college student aid commission, until the department receives a withdrawal of the certificate of noncompliance or unless an application has been filed pursuant to Iowa Code section 261.127.

This rule is intended to implement Iowa Code sections 252J.8, 252J.9, 261.126, 261.127, 321.13, 321.177, 321.210, and 321.212.

[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—600.5 to **600.11** Reserved.

761—600.12(321) Private and commercial driver education schools. Rescinded IAB 3/31/04, effective 5/5/04.

761—600.13(321) Behind-the-wheel instructor's certification. Rescinded IAB 3/31/04, effective 5/5/04.

761—600.14(321) Payment of fees. Rescinded IAB 3/31/04, effective 5/5/04.

761—600.15 Reserved.

761—600.16(321) Seat belt exemptions.

600.16(1) A person who is unable to wear a safety belt or safety harness for physical or medical reasons may obtain a form to be signed by the person's health care provider licensed under Iowa Code chapter 148 or 151. Form No. 432017, "Iowa Medical Safety Belt Exemption," is available from the office of driver services at the address in rule 761—600.2(17A).

600.16(2) Iowa Code section 321.445, subsections 1 and 2, shall not apply to the front seats and front seat passengers of motor vehicles owned, leased, rented or primarily used by a person with a physical disability who uses a collapsible wheelchair.

This rule is intended to implement Iowa Code section 321.445.

[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

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◊ Two or more ARCs

1 Effective date of 761—600.13(321) delayed 70 days by the Administrative Rules Review Committee at its meeting held December 9, 1998. At its meeting held January 5, 1999, the Committee delayed the effective date until adjournment of the 1999 Session of the General Assembly.

CHAPTER 604
LICENSE EXAMINATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C)rules 13.3 and 13.17]

761—604.1(321) Authority and scope.

604.1(1) The department is authorized to determine by examination an applicant's ability to operate motor vehicles safely upon the highways and to issue all driver's licenses.

604.1(2) This chapter of rules shall apply to the examination for all driver's licenses. Information on the additional examination procedures and requirements for a commercial driver's license or commercial driver's instruction permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code sections 321.2, 321.3, 321.13, 321.177, and 321.186.

761—604.2(321) Definitions.

"Binocular field of vision" is the sum of the temporal measurements or the sum of the nasal measurements.

"Monocular field of vision" is the sum of the temporal measurement and the nasal measurement for one eye.

"Representative vehicle" is a vehicle which is characteristic of and requires operating skills comparable to those vehicles that may legally be operated under the class of license or endorsement desired.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.

[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—604.3(17A) Information and forms.

604.3(1) Applications, forms, and information about driver's license examinations are available at any driver's license examination station. Assistance is also available from the office of driver services at the address in 761—600.2(17A).

604.3(2) The "Iowa Driver Manual" and the "Iowa Motorcycle Operator Manual" are also available from the department.

This rule is intended to implement Iowa Code section 17A.3.

761—604.4 to **604.6** Reserved.

761—604.7(321) Examination.

604.7(1) An examination shall include:

a. A vision screening if the person has not filed a vision report.

b. A knowledge test of Iowa traffic laws and highway signs.

c. A driving test of the person's ability to operate a motor vehicle.

604.7(2) The examination required for a driver's license depends upon the class of license requested, applicable endorsements, and the qualifications of the applicant.

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

761—604.8 and **604.9** Reserved.

761—604.10(321) Vision screening.

604.10(1) *Requirement.* Vision screening or a vision report is required of an applicant for a driver's license.

604.10(2) *Method.* At driver's license examination stations, a vision screening instrument shall be used to screen the applicant's vision. An applicant who has corrective lenses may be screened with or without the corrective lenses.

604.10(3) *Report.* A vision report shall be submitted on Form 430032 signed by a licensed vision specialist and shall report the person's visual acuity level and field of vision as measured within 30 days prior to the date of the application. In lieu of Form 430032, a vision report signed by a licensed vision

specialist on the specialist's letterhead may be accepted if it contains all the information specified on Form 430032.

This rule is intended to implement Iowa Code sections 321.186, 321.186A and 321.196.
[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—604.11(321) Vision standards. The visual acuity and field of vision standards for licensing and the applicable restrictions are as follows.

604.11(1) *Visual acuity standards.*

a. When the applicant is screened without corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, no restriction will be imposed. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be restricted from driving when headlights are required.

b. When the applicant is screened with corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, the applicant shall be required to wear corrective lenses. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be required to wear corrective lenses and shall be restricted from driving when headlights are required.

c. Other standards. If the visual acuity in the left eye is less than 20/100, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors. However, if the applicant has a visual acuity of 20/40 in the right eye and less than 20/100 in the left eye without corrective lenses and has corrective lenses that improve the vision in the left eye to better than 20/100, the applicant shall have the option of being restricted to driving with corrective lenses or driving a vehicle with both left and right outside rearview mirrors.

604.11(2) *Field of vision standards.*

a. If the binocular field of vision is at least 140 degrees, no restriction will be imposed.

b. If the binocular field of vision is less than 140 degrees but at least 110 degrees, or one eye has a monocular field of vision of at least 100 degrees, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors.

This rule is intended to implement Iowa Code sections 321.186, 321.193, and 321.196.
[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—604.12(321) Vision referrals.

604.12(1) *Referral.*

a. If an applicant on first screening cannot attain 20/40 but can attain 20/70 with at least one eye, the department shall not issue a license to the applicant. Instead, the department shall advise the applicant to consult a licensed vision specialist.

b. A vision report, pursuant to subrule 604.10(3), shall be required before the department will reconsider licensing.

604.12(2) *License.*

a. The department shall affix a sticker to the applicant's license stating: "Renewal or license issuance denied due to vision."

b. If the applicant's license is valid for less than 30 days, the department may issue a temporary driving permit with restrictions appropriate to the applicant's visual acuity level and field of vision. The temporary driving permit is valid for not more than 30 days from the end of the current license validity.

604.12(3) *Report.* If the vision report recommends a restriction, the department shall issue a restricted license even though it would not be required by departmental standards.

604.12(4) *Applicant refusal.* If an applicant refuses to consult a licensed vision specialist, the department shall issue or deny the license based on the results achieved on the vision screening.

This rule is intended to implement Iowa Code sections 321.181, 321.186, 321.186A, 321.193 and 321.196.

761—604.13(321) Vision screening results.

604.13(1) *Two-year license.* An applicant who cannot attain a visual acuity of 20/40 with both eyes or with the better eye shall be issued a two-year license. This restriction may be waived by the department

when a vision report pursuant to subrule 604.10(3) certifies that the vision has stabilized and is not expected to deteriorate.

604.13(2) *License denied.*

a. An applicant who cannot attain a visual acuity of 20/70 with both eyes or with the better eye shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

b. If the applicant's binocular field of vision is less than 110 degrees, or the monocular field of vision is less than 100 degrees, the applicant shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

604.13(3) *Reapplication.* An applicant who cannot meet the vision standards in subrule 604.13(2) may reapply when the vision improves and meets the vision standards. If a suspension or denial notice was served, reapplication must be made to the office of driver services at the address in 761—600.2(17A), and not at a driver's license examination station.

604.13(4) *Discretionary issuance.*

a. An applicant whose license is restricted under rule 761—604.11(321) or who cannot meet the vision standards in subrule 604.13(2) may submit a written request for review by an informal settlement officer.

b. Based upon consideration of the applicant's vision screening results or vision report, driving test and driving record, the written recommendation of the applicant's licensed vision specialist, and traffic conditions in the vicinity of the applicant's residence, the officer may recommend issuing a license with restrictions suitable to the applicant's capabilities. However:

(1) An applicant who cannot attain a visual acuity of 20/100 with both eyes or with the better eye may be considered for licensing only after recommendation by the medical advisory board.

(2) An applicant who cannot attain a visual acuity of 20/199 with both eyes or with the better eye shall not be licensed.

(3) If an applicant's binocular field of vision or monocular field of vision is less than 75 degrees, the applicant may be considered for licensing only after recommendation by the medical advisory board.

(4) An applicant who cannot attain a binocular or monocular field of vision of 21 degrees shall not be licensed.

c. The officer's recommendation denying discretionary issuance or regarding the extent and nature of restrictions is subject to reversal or modification upon review or appeal only if it is clearly characterized by an abuse of discretion.

This rule is intended to implement Iowa Code sections 321.186, 321.186A, 321.193 and 321.196.
[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—604.14 to **604.19** Reserved.

761—604.20(321) Knowledge test.

604.20(1) *Written test.* A knowledge test is a written test to determine an applicant's ability to read and understand Iowa traffic laws and the highway signs that regulate, warn, and direct traffic. A test may be revised at any time but each test states the minimum passing score.

604.20(2) *Three types of tests.* There are three types of knowledge tests: an operator's test, a chauffeur's test, and a motorcycle test. The requirement for a license depends upon the class of license desired, applicable endorsements, and the qualifications of the applicant.

604.20(3) *Oral test.* An applicant who is unable to read or understand a written test may request an oral test. The oral test may be administered by an examiner or by an automated testing device.

604.20(4) *Waiver.* Rescinded IAB 1/8/92, effective 2/12/92.

This rule is intended to implement Iowa Code section 321.186.

761—604.21(321) Knowledge test requirements and waivers.

604.21(1) *Knowledge test requirements.* The knowledge test requirements are as follows:

a. Operator's test. An operator's knowledge test is required for all classes of driver's licenses and all types of special driver's licenses and permits.

b. *Motorcycle test.* A motorcycle knowledge test is required for all:

(1) Motorcycle instruction permits.

(2) Class M driver's licenses.

(3) Motorcycle endorsements.

c. *Chauffeur's test.* A chauffeur's knowledge test is required for all:

(1) Chauffeur's instruction permits.

(2) Class D driver's licenses except those with an endorsement for "passenger vehicle less than 16-passenger design."

604.21(2) *Knowledge test waivers.* The department may waive a knowledge test listed in subrule 604.21(1) if the applicant meets one of the following qualifications:

a. The applicant has passed the same type of test for another Iowa driver's license or an equivalent out-of-state license that is still valid.

b. The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

c. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

This rule is intended to implement Iowa Code sections 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.196 and 321.198.

761—604.22(321) Knowledge test results.

604.22(1) *Proof of Passing score.* When necessary, the department shall give the applicant a form, valid for 90 days, which certifies that the applicant has passed the knowledge test.

604.22(2) *Retesting.* An applicant who fails a knowledge test may repeat the test at the discretion of the examiner, but at least two hours shall elapse between tests.

This rule is intended to implement Iowa Code section 321.186.

761—604.23 to **604.29** Reserved.

761—604.30(321) Driving test. A driving test is a demonstration of an applicant's ability to exercise ordinary and reasonable control in the operation of a motor vehicle under actual traffic conditions. The test is also called a road test, field test, or driving demonstration. A motorcycle skill test is an off-street demonstration of an applicant's ability to control the motorcycle in a set of standard maneuvers, and a motorcycle driving test is an on-street demonstration.

604.30(1) *Vehicle type and safety.*

a. For the driving test, the applicant shall provide a representative vehicle as defined in 761—604.2(321).

b. The examiner or other authorized personnel shall visually inspect the vehicle. If a vehicle is illegal or unsafe, or is not a representative vehicle, the examiner shall refuse to administer the test until corrections are made or an acceptable vehicle is provided.

604.30(2) *Criteria and route.* Form 430024, "Your Driving Test," explains the criteria for passing the test and shall be given to the applicant before any required test, except a motorcycle skill test. The applicant shall be directed over one of the routes which have been preselected by the examiner to test driving skills and maneuvers.

604.30(3) *Test score.* The examiner shall use the standard departmental score sheet and shall enter the test score and the licensing decision in the spaces provided. At the end of the test, the examiner shall explain the test score. The test score result is valid for 90 days.

604.30(4) *Retesting.* If an applicant fails a driving test, the test may be rescheduled at the discretion of the examiner.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.

[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—604.31(321) Driving test requirements and waivers for noncommercial driver's licenses.

604.31(1) *Driving test requirements.* The driving test requirements for noncommercial driver's licenses are as follows:

a. Instruction permits. A driving test is not required to obtain an instruction permit.

b. Class C driver's licenses. For a Class C driver's license other than an instruction permit or a motorized bicycle license, an operator's driving test in a representative vehicle is required.

c. Class D driver's licenses. For a Class D driver's license, a driving test in a representative vehicle for the endorsement requested, as set out in 761—subrule 605.4(2), is required.

d. Class M driver's licenses and motorcycle endorsements. The driving test for a Class M driver's license or motorcycle endorsement consists of two parts: an off-street motorcycle skill test and an on-street driving test.

(1) The off-street motorcycle skill test is required. The on-street motorcycle driving test is also required if the applicant does not have another driver's license that permits unaccompanied driving.

(2) A motorcycle shall be used for these tests. If a three-wheeled motorcycle is used, the driver's license shall be restricted: "Not valid for 2-wheel vehicle."

e. Motorized bicycle licenses. For a motorized bicycle license, an off-street or on-street driving test may be required. A motorized bicycle shall be used for the test.

604.31(2) *Driving test waivers.* The department may waive a required driving test listed in subrule 604.31(1) if the applicant meets one of the following qualifications:

a. The applicant is applying for the applicant's first Iowa driver's license that permits unaccompanied driving following successful completion of the appropriate Iowa-approved course or courses. The appropriate Iowa-approved courses are the following: driver education for a Class C driver's license other than motorized bicycle, driver education and motorcycle rider education for a Class M driver's license or motorcycle endorsement, and motorized bicycle education for a motorized bicycle license. However:

(1) The department may select dates and require a driving test of applicants whose birth dates fall on the selected dates. The department shall notify the Iowa department of education quarterly of the dates selected.

(2) If an applicant is under the age of 18, a driving test is required if so requested by the applicant's parent, guardian, or instructor.

b. The applicant is renewing a Class C, Class D or Class M Iowa driver's license or endorsement within 14 months after the expiration date.

c. The applicant has passed the same type of driving test for another Iowa driver's license or endorsement that is still valid or has expired within the past 14 months.

d. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

e. The applicant is applying for a Class C Iowa driver's license that permits unaccompanied driving and has an equivalent out-of-state license that is valid or has expired within the past year.

f. The applicant is applying for a Class D Iowa driver's license and has an equivalent out-of-state license that is valid or has expired within the past year.

g. The applicant is applying for a Class M driver's license or a motorcycle endorsement and has an equivalent out-of-state Class M driver's license or motorcycle endorsement that is valid or has expired within the past year.

h. The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

This rule is intended to implement Iowa Code sections 321.174, 321.178, 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.193, 321.196 and 321.198.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—604.32(321) Driving tests requirements. Rescinded IAB 1/8/92, effective 2/12/92.

761—604.33 and **604.34** Reserved.

761—604.35(321) Determination of gross vehicle weight rating. For a vehicle that has no legible manufacturer's certification label, the applicant may provide documentation of the gross vehicle weight rating, such as a manufacturer's certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

This rule is intended to implement Iowa Code section 321.1.

761—604.36 to **604.39** Reserved.

761—604.40(321) Failure to pass examination.

604.40(1) An applicant who fails to pass a required examination or reexamination shall not be licensed.

a. If the applicant does not have a valid Iowa license, the department shall deny the applicant a license.

b. If the applicant has a valid Iowa license, the department shall suspend the license for incapability. However, if the applicant's license is valid for less than 30 days, the department shall deny further licensing. The department shall serve a notice of suspension or denial.

c. See 761—615.4(321) for further information on denials and 761—615.14(321) for further information on suspensions for incapability.

d. An applicant may contest a denial or suspension in accordance with 761—615.38(321).

604.40(2) Limitations on the hearing and appeal process.

a. After a suspension or denial for failure to pass a required knowledge or driving test, a person who contests the suspension or denial shall be deemed to have exhausted the person's administrative remedies after three unsuccessful attempts to pass the required test.

b. After the three unsuccessful attempts, no further testing shall be allowed until six months have elapsed from the date of the last test failure, and then only if the applicant demonstrates a significant change or improvement in those physical or mental factors that resulted in the original decision. A request for further testing must be submitted in writing to the office of driver services at the address in rule 761—600.2(17A).

c. Notwithstanding paragraphs *"a"* and *"b"* of this subrule, no testing shall occur if the director determines that it is unsafe to allow testing.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177, 321.180A and 321.210.

761—604.41 to **604.44** Reserved.

761—604.45(321) Reinstatement. A person whose license has been suspended or denied for failure to pass a required examination or reexamination shall meet the vision standards for licensing, pass the required knowledge examination(s), and pass the required driving test(s) before an Iowa license will be issued.

This rule is intended to implement Iowa Code sections 321.177 and 321.186.

761—604.46 to **604.49** Reserved.

761—604.50(321) Special reexaminations. The department may require a special reexamination consisting of a vision screening, knowledge test and driving test of any licensee.

604.50(1) The department may require a special reexamination when a licensee has been involved in a fatal motor vehicle accident and the investigating officer's report of the accident indicates the licensee contributed to the accident.

604.50(2) The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officer's report of each accident lists one of the following "Driver/Vehicle Related Contributing Circumstances" for the licensee:

a. Ran traffic signal.

b. Ran stop sign.
c. Passing, interfered with other vehicle.
d. Left of center, not passing.
e. Failure to yield right-of-way at uncontrolled intersection.
f. Failure to yield right-of-way from stop sign.
g. Failure to yield right-of-way from yield sign.
h. Failure to yield right-of-way making left turn.
i. Failure to yield right-of-way to pedestrian.
j. Failure to have control.

604.50(3) The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officers' reports for both accidents list a driver condition for the licensee of "apparently asleep."

604.50(4) The department may require a special reexamination when a licensee who is 65 years of age or older has been involved in an accident and information in the investigating officer's or the person's own report of the accident indicates the need for reexamination. A circumstance that may indicate a need for reexamination includes, but is not limited to, any one of the following:

a. The licensee made a left turn that resulted in the accident.
b. The licensee failed to yield the right-of-way at a stop sign.
c. The licensee failed to yield the right-of-way at a yield sign.
d. The licensee failed to yield the right-of-way at an uncontrolled intersection.
e. The licensee failed to yield the right-of-way at a traffic control signal.
f. The licensee's vision may be a contributing factor to a nighttime accident.
g. The licensee has a physical disability-related license restriction other than "corrective lenses" and the accident involved one of the circumstances listed in paragraphs *"a"* to *"f"* above.

604.50(5) The department may require a special reexamination when recommended by a peace officer, a court, or a properly documented citizen's request. A factor that may indicate a need for reexamination includes, but is not limited to, any one of the following:

a. Loss of consciousness.
b. Confusion, disorientation or dementia.
c. Inability to maintain a vehicle in the proper lane.
d. Repeatedly ignoring traffic control devices in a nonchase setting.
e. Inability to interact safely with other vehicles.
f. Inability to maintain consistent speed when no reaction to other vehicles or pedestrians is required.

This rule is intended to implement Iowa Code sections 321.177, 321.186 and 321.210.

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[1] Effective date of 604.11(2) and 604.13(2)*"b"* delayed until adjournment of the 1988 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its June 1987 meeting.

CHAPTER 605
LICENSE ISSUANCE

761—605.1(321) Scope. This chapter of rules applies to the issuance of all Iowa driver's licenses. Additional information on the issuance of a commercial driver's license or a commercial driver's instruction permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code section 321.174.

761—605.2(321) Contents of license. In addition to the information specified in Iowa Code subsection 321.189(2), the following information shall be shown on a driver's license.

605.2(1) *Address.* A business address shall be used only when the licensee does not have an Iowa address and will not be able to establish a residence address in Iowa.

605.2(2) *Physical description.* The physical description of the licensee on the face of the driver's license shall include:

a. The licensee's eye color using these abbreviations: Blk-black, Blu-blue, Bro-brown, Gry-gray, Grn-green, Haz-hazel, and Pnk-pink.

b. The licensee's height in inches.

c. Rescinded IAB 11/8/06, effective 12/13/06.

This rule is intended to implement Iowa Code section 321.189.

761—605.3(321) License class. The driver's license class shall be coded on the face of the driver's license using these codes:

Class A—commercial driver's license
Class B—commercial driver's license
Class C—commercial driver's license
Class C—noncommercial driver's license
Class D—noncommercial driver's license, chauffeur
Class M—noncommercial driver's license, motorcycle only

This rule is intended to implement Iowa Code section 321.189.

761—605.4(321) Endorsements. The endorsements shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

605.4(1) *For a commercial driver's license.* The following endorsements may be added to a Class A, B or C commercial driver's license using these letter codes:

H—Hazardous material
P—Passenger
N—Tank
X—Hazardous material and tank
T—Double/triple trailers
S—School bus

605.4(2) *For a Class D driver's license (chauffeur).* The following endorsements may be added to a Class D driver's license using these number codes:

1—Truck-tractor semitrailer combination

2—Vehicle with 16,001 pounds gross vehicle weight rating or more. Not valid for truck-tractor semitrailer combination

3—Passenger vehicle less than 16-passenger design

605.4(3) *Motorcycle endorsement.* A motorcycle endorsement may be added to any driver's license that permits unaccompanied driving, other than a Class M driver's license or a motorized bicycle license, using the following letter code:

L—Motorcycle

This rule is intended to implement Iowa Code section 321.189.

761—605.5(321) Restrictions. Restrictions shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

605.5(1) *For all licenses.* The following restrictions may apply to any driver's license:

B—Corrective lenses required
C—Mechanical aid (as detailed in the restriction on the back of the card)
D—Prosthetic aid (as detailed in the restriction on the back of the card)
E—Automatic transmission
F—Left and right outside rearview mirrors
G—No driving when headlights required
H—Temporary restricted license or permit (work permit)
I—Ignition interlock required
J—Restrictions on the back of card
S—SR required (proof of financial responsibility for the future)
T—Medical report required at renewal
U—Not valid for 2-wheel vehicle
W—Restricted commercial driver's license (CDL)
Y—Intermediate license

605.5(2) *For a noncommercial driver's license.* The following restrictions apply only to a noncommercial driver's license:

P—Special instruction permit
Q—No interstate or freeway driving

605.5(3) *For a commercial driver's license.* The following restrictions apply only to a commercial driver's license:

K—Commercial driver's license intrastate only
L—Vehicle without air brakes
M—Except Class A bus
N—Except Class A and Class B bus
O—Except tractor-trailer
V—Medical Variance document required

605.5(4) *Special licenses.* A numbered restriction will designate a special driver's license using these codes:

1—Motorcycle instruction permit
2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)
3—Commercial driver's instruction permit
4—Chauffeur's instruction permit
5—Motorized bicycle license
6—Minor's restricted license
7—Minor's school license

605.5(5) *Additional information.*

a. Reexamination or report. The department may issue a restriction requiring a person to reappear at a specified time for examination. The department may require a medical report to be submitted. The department shall send Form 430029 as a reminder to appear.

b. Loss of consciousness or voluntary control.

(1) If a person is licensed pursuant to 761—subrule 600.4(4), the department shall issue the first driver's license with a restriction stating: "Medical report to be furnished at the end of six months."

(2) If this medical report shows that the person has been free of an episode of loss of consciousness or voluntary control since the previous medical report and the report recommends licensing, the department shall issue a duplicate driver's license with a restriction stating: "Medical report required at renewal." At each renewal accompanied by a favorable medical report, the department shall issue a two-year driver's license with the same restriction.

(3) If the latest medical report indicates the person experienced only a single nonrecurring episode, the cause has been identified, and the physician is not treating or has not treated the person for the episode

and believes it is unlikely to recur, the department may waive the medical report requirement upon receipt of a favorable recommendation from a physician.

(4) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a physician and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control and has not been prescribed medications to control such episodes during the 24-month period immediately preceding application for a license.

(5) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a physician and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control during the 10-year period immediately preceding application for a license.

c. Financial responsibility. When a person is required under Iowa Code chapter 321A to have future proof of financial responsibility on file, the license restriction will read: "SR required." The license shall be valid only for the operation of motor vehicles covered by the class of license issued and by the proof of financial responsibility filed.

d. Vision restriction. Restrictions relating to vision are addressed in 761—Chapter 604.

This rule is intended to implement Iowa Code chapter 321A and sections 321.178, 321.180, 321.180A, 321.180B, 321.189, 321.193, 321.194, 321.215, 321J.4, and 321J.20.
[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—605.6 Reserved.

761—605.7(321L) Handicapped designation. Rescinded IAB 2/11/98, effective 3/18/98.

761—605.8 Reserved.

761—605.9(321) Fees for driver's licenses. Fees for driver's licenses are specified in Iowa Code section 321.191. A license fee may be paid by cash, check, credit card, debit card or money order. If payment is by check, the following requirements apply:

605.9(1) The check shall be for the exact amount of the fee and shall be payable to: Treasurer, State of Iowa. An exception may be made when a traveler's check is presented.

605.9(2) One check may be used to pay fees for several persons, such as members of a family or employees of a business firm. One check may pay all fees involved, such as the license fee and the reinstatement fee.

This rule is intended to implement Iowa Code section 321.191.
[**ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—605.10(321) Waiver or refund of license fees. Rescinded IAB 2/8/12, effective 3/14/12.

761—605.11(321) Duplicate license.

605.11(1) *Lost or destroyed license.* To replace a valid license that is lost or destroyed, the licensee shall submit Form 430052 and proof of age, identity and social security number. The replacement fee is $3.

605.11(2) *Voluntary replacement.* The department shall issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the $1 voluntary replacement fee is paid. Voluntary replacement includes but is not limited to:

a. Replacement of a damaged license.

b. Replacement to change the address on a license.

c. Replacement to change the name on a license. The licensee shall submit an affidavit of the name change on Form 430043. The affidavit must be accompanied by one of the following documents:

(1) Court-ordered name change. It must contain the full name, date of birth, and court seal.

(2) Divorce decree.

(3) Marriage certificate.

d. Replacement to change the sex on a license. The licensee shall submit court documentation of the sex change.

e. Issuance of a license without the words "under 21" to a licensee who is 21 years of age or older.

f. Issuance of a license without the words "under 18" to a licensee who is 18 years of age or older. (If the licensee is under 21 years of age, the words "under 21" will replace the words "under 18.")

g. Issuance of a noncommercial driver's license to an eligible person who has been disqualified from operating a commercial motor vehicle.

h. Replacement of a valid license before its expiration date to obtain a license issued under the new classification system.

This rule is intended to implement Iowa Code sections 321.189, 321.195, and 321.208.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—605.12(321) Address changes.

605.12(1) A licensee shall notify the department of a change in the licensee's mailing address within 30 days of the change. Notice shall be given by:

a. Submitting the address change in writing to the office of driver services, or

b. Appearing in person to change the mailing address at any driver's license examination station.

605.12(2) Parents or legal guardians may provide written notice of a mailing address change on behalf of their minor children.

605.12(3) The department may use U.S. Postal Service address information to update its address records.

This rule is intended to implement Iowa Code sections 321.182 and 321.184.

761—605.13 and **605.14** Reserved.

761—605.15(321) License extension.

605.15(1) *Six-month extension.* An Iowa resident may apply for a six-month extension of a license if the resident:

a. Has a valid license,

b. Is eligible for further licensing, and

c. Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

605.15(2) *Procedure.* The licensee shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver's license examination station. The licensee may also apply by letter to the address in 761—600.2(17A).

a. A six-month extension shall be added to the expiration date on the license. When the licensee appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

b. The department shall allow only two six-month extensions.

This rule is intended to implement Iowa Code section 321.196.

761—605.16(321) Military extension.

605.16(1) *Form 430028.* A person who qualifies for a military extension of a valid license should request Form 430028 from the department and carry it with the license for verification to peace officers. Form 430028 explains the provisions of Iowa Code section 321.198 regarding military extensions.

605.16(2) *Request for retention of record.* A person with a military extension may request that the department retain the record of license issuance for the duration of the extension or reenter the record if it has been removed from department records. The request may be made by letter or by using Form 430081. The letter or Form 430081 shall be signed by the person's commanding officer to verify the military service and shall be submitted to the department at the address in 761—600.2(17A).

605.16(3) *Renewal of license after military extension.* When an applicant renews a license after a military extension, the department may require the applicant to provide documentation of both the military service and the date of separation from military service.

605.16(4) *Reinstatement after sanction.* A person with a military extension whose license has been canceled, suspended or revoked shall comply with the requirements of 761—615.40(321) to reinstate the license.

This rule is intended to implement Iowa Code section 321.198.

761—605.17 to **605.19** Reserved.

761—605.20(321) Fee adjustment for upgrading license. The fee for upgrading a driver's license shall be computed on a full-year basis. The fee is charged for each year or part of a year between the date of the change and the expiration date on the license.

605.20(1) The fee to upgrade a driver's license from one class to another is determined by computing the difference between the current license fee and the new license fee as follows:

a. Converting noncommercial Class C to Class D—$4 per year of new license validity.

b. Converting Class M to Class D with a motorcycle endorsement—$4 per year of new license validity.

c. Converting Class M to noncommercial Class C with a motorcycle endorsement—$1 one-time fee.

605.20(2) The fee to add a privilege to a driver's license is computed per year of new license validity as follows:

Noncommercial Class C (full privileges from a restricted Class C)	$4 per year
Motorized bicycle	$4 per year
Minor's restricted license	$4 per year
Minor's school license	$4 per year
Motorcycle instruction permit	$1 per year
Motorcycle endorsement	$1 per year

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

761—605.21 to **605.24** Reserved.

761—605.25(321) License renewal.

605.25(1) A licensee who wishes to renew a license shall apply at a driver's license examination station and, if required, pass the appropriate examination.

605.25(2) A valid license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier.

605.25(3) A valid license may be renewed within 60 days after the expiration date, unless otherwise specified.

This rule is intended to implement Iowa Code sections 321.186 and 321.196.

761—605.26(321) License renewal by mail. Rescinded IAB 3/20/02, effective 4/24/02.

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CHAPTER 615
SANCTIONS
[Prior to 6/3/87, Transportation Department[820]—(07,C) Ch 6]

761—615.1(321) Definitions. The definitions in 761—600.1(321) apply to this chapter. In addition:

"Accident free" as used in Iowa Code section 321.180B means the driver has not been involved in a contributive accident. "Involvement in a motor vehicle accident" as used in Iowa Code section 321.180B means involvement in a contributive accident.

"Contributive accident" means an accident for which there is evidence in departmental records that the driver performed an act which resulted in or contributed to the accident, or failed to perform an act which would have avoided or contributed to the avoidance of the accident.

"Conviction free" as used in Iowa Code section 321.180B means the driver has not been convicted of a moving violation.

"Deny" or *"denial"* means a rejection of an application for a license or a refusal to issue, renew or reinstate a license.

"Moving violation," unless otherwise provided in this chapter, means any violation of motor vehicle laws except:

1. Violations of equipment standards to be maintained for motor vehicles.
2. Parking violations as defined in Iowa Code section 321.210.
3. Child restraint and safety belt and harness violations under Iowa Code sections 321.445 and 321.446.
4. Violations of registration, weight and dimension laws.
5. Operating with an expired license.
6. Failure to appear.
7. Disturbing the peace with a motor vehicle.
8. Violations of Iowa Code Supplement section 321.20B for failure to provide proof of financial liability coverage.

"Sanction" means a license denial, cancellation, suspension, revocation, bar or disqualification.

This rule is intended to implement Iowa Code sections 321.1, 321.178, 321.180A, 321.189, 321.194, 321.210, 321.215, 321.445, 321.446 and 321.555.

761—615.2(321) Scope. This chapter of rules applies to any license, as defined in 761—600.1(321). However:

615.2(1) Rules specifically addressing denial, cancellation or disqualification of a commercial driver's license are found in 761—Chapter 607, "Commercial Driver Licensing."

615.2(2) Rules implementing Iowa Code chapter 321J are found in 761—Chapter 620, "OWI and Implied Consent."

615.2(3) Rules implementing Iowa Code chapter 321A are found in 761—Chapter 640, "Financial Responsibility."

This rule is intended to implement Iowa Code chapters 321, 321A and 321J.

761—615.3(17A) Information and address. Applications, forms and information concerning license sanctions are available at any driver's license examination station or at the address in 761—600.2(17A).

This rule is intended to implement Iowa Code section 17A.3.

761—615.4(321) Denial for incapability.

615.4(1) A person who has a valid Iowa license that would otherwise be suspended for incapability shall, in lieu of a suspension, be denied further licensing if there is less than 30 days' validity on the license.

a. The denial shall be effective when the license is no longer valid.

b. The license shall be surrendered to the department. The department shall issue a temporary driving permit which allows the person to drive until the effective date of the denial.

615.4(2) If a person who is denied licensing for incapability does not have a valid Iowa license, the department may refuse orally to issue a license, effective immediately, or may deny licensing in writing, effective on the date the denial notice is served.

This rule is intended to implement Iowa Code sections 321.177 and 321.210.

761—615.5 and **615.6** Reserved.

761—615.7(321) Cancellations.

615.7(1) The department shall cancel the license of an unmarried minor upon receipt of a written withdrawal of consent from the person who consented to the minor's application. The department shall also cancel a minor's license upon receipt of evidence of the death of the person who consented to the minor's application.

615.7(2) The department shall cancel a motorized bicycle license when the licensee is convicted of one moving violation. Reapplication may be made 30 days after the date of cancellation.

615.7(3) The department may cancel a license when the person was not entitled or is no longer entitled to a license, failed to give correct and required information, or committed fraud in applying.

615.7(4) A cancellation shall begin ten days after the department's notice of cancellation is served.

This rule is intended to implement Iowa Code sections 321.184, 321.185, 321.189, 321.201 and 321.215.

761—615.8 Reserved.

761—615.9(321) Habitual offender.

615.9(1) The department shall declare a person to be a habitual offender under Iowa Code subsection 321.555(1) in accordance with the following point system:

a. Points shall be assigned to convictions as follows:

Conviction	Points
Perjury or the making of a false affidavit or statement under oath to the department of public safety	2 points
Driving while under suspension, revocation or denial (except Iowa Code chapter 321J)	2 points
Driving while under Iowa Code chapter 321J revocation or denial	3 points
Driving while barred	4 points
Operating a motor vehicle in violation of Iowa Code section 321J.2	4 points
An offense punishable as a felony under the motor vehicle laws of Iowa or any felony in the commission of which a motor vehicle is used	5 points
Failure to stop and leave information or to render aid as required by Iowa Code sections 321.261 and 321.263	5 points
Eluding or attempting to elude a pursuing law enforcement vehicle in violation of Iowa Code section 321.279	5 points
Serious injury by a vehicle in violation of Iowa Code subsection 707.6A(3)	5 points
Manslaughter resulting from the operation of a motor vehicle	6 points

b. Based on the points accumulated, the person shall be barred from operating a motor vehicle on the highways of this state as follows:

Points	Length of bar
6 – 7	2 years
8 – 9	3 years
10 – 12	4 years
13 – 15	5 years
16+	6 years

615.9(2) A person declared to be a habitual offender under Iowa Code subsection 321.555(2) shall be barred from operating a motor vehicle on the highways of this state for one year.

615.9(3) A person declared to be a habitual offender under Iowa Code Supplement section 321.560, unnumbered paragraph 2, shall be barred from operating a motor vehicle on the highways of this state beginning on the date the previous bar expires.

This rule is intended to implement Iowa Code sections 321.555, 321.556 and 321.560.

761—615.10 Reserved.

761—615.11(321) Periods of suspension.

615.11(1) *Length.* The department shall not suspend a person's license for less than 30 days nor for more than one year unless a statute specifies or permits a different period of suspension.

615.11(2) *Extension of suspension.* The department shall extend the period of license suspension for an additional like period when the person is convicted of operating a motor vehicle while the person's license is suspended, unless a statutory exception applies. If the person's driving record does not indicate what the original grounds for suspension were, the period of license suspension shall not exceed six months.

This rule is intended to implement Iowa Code sections 321.212 and 321.218.

761—615.12(321) Suspension of a habitually reckless or negligent driver.

615.12(1) The department may suspend a person's license if the person is a habitually reckless or negligent driver of a motor vehicle.

a. *"Habitually reckless or negligent driver"* means a person who has accumulated a combination of three or more contributive accidents and convictions for moving violations or three or more contributive accidents within a 12-month period.

b. *"Contributive or contributed"* means that there is evidence in departmental records that the driver performed an act which resulted in or contributed to an accident, or failed to perform an act which would have avoided or contributed to the avoidance of an accident.

615.12(2) In this rule, the speeding violations specified in Iowa Code paragraph 321.210(2)*"d"* are not included.

615.12(3) The suspension period shall be at least 60 days.

This rule is intended to implement Iowa Code section 321.210.

761—615.13(321) Suspension of a habitual violator.

615.13(1) The department may suspend a person's license when the person is a habitual violator of the traffic laws. "Habitual violator" means that the person has been convicted of three or more moving violations committed within a 12-month period.

615.13(2) The minimum suspension periods shall be as follows unless reduced by a driver's license hearing officer based on mitigating circumstances:

3 convictions in 12 months	90 days
4 convictions in 12 months	120 days
5 convictions in 12 months	150 days
6 convictions in 12 months	180 days
7 or more convictions in 12 months	1 year

615.13(3) In this rule, the speeding violations specified in Iowa Code paragraph 321.210(2)*"d"* are not included.

This rule is intended to implement Iowa Code section 321.210.

761—615.14(321) Suspension for incapability. The department may suspend a person's license when the person is incapable of safely operating a motor vehicle.

615.14(1) Suspension for incapability may be based on one or more of the following:

a. Receipt of a medical report stating that the person is not physically or mentally capable of safely operating a motor vehicle.

b. Failure of the person to appear for a required reexamination or failure to submit a required medical report within the specified time.

c. Ineligibility for licensing under Iowa Code subsections 321.177(4) to 321.177(7).

615.14(2) The suspension period shall be indefinite but shall be terminated when the department receives satisfactory evidence that the licensee has been restored to capability.

615.14(3) A person whose license has been suspended for incapability may be eligible for a special noncommercial instruction permit under rule 761—602.21(321).

This rule is intended to implement Iowa Code sections 321.177, 321.210, and 321.212.

761—615.15(321) Suspension for unlawful use of a license.

615.15(1) The department may suspend a person's license when the person has been convicted of unlawful or fraudulent use of the license or if the department has received other evidence that the person has violated Iowa Code section 321.216, 321.216A or 321.216B.

615.15(2) The suspension period shall be at least 30 days.

615.15(3) A suspension for a violation of Iowa Code section 321.216B shall not exceed six months.

This rule is intended to implement Iowa Code sections 321.210, 321.212, 321.216, 321.216A and 321.216B.

761—615.16(321) Suspension for out-of-state offense. The department may suspend a person's license when the department is notified by another state that the person committed an offense in that state which, if committed in Iowa, would be grounds for suspension. The notice may indicate either a conviction or a final administrative decision. The period of the suspension shall be the same as if the offense had occurred in Iowa.

This rule is intended to implement Iowa Code sections 321.205 and 321.210.

761—615.17(321) Suspension for a serious violation.

615.17(1) The department may suspend a person's license when the person has committed a serious violation of the motor vehicle laws.

615.17(2) *"Serious violation"* means that:

a. The person's conviction for a moving violation was accompanied by a written report from the arresting officer, the prosecuting attorney or the court indicating that the violation was unusually serious. The suspension period shall be at least 60 days.

b. The person was convicted of a moving violation which contributed to a fatal motor vehicle accident. "Contributed" is defined in paragraph 615.12(1)*"b."* The suspension period shall be at least 120 days.

c. The person was convicted for speeding 25 miles per hour (mph) or more above the legal limit. The minimum suspension period shall be as follows unless reduced by a driver's license hearing officer based on mitigating circumstances:

25 mph over the legal limit	60 days
26 mph over the legal limit	65 days
27 mph over the legal limit	70 days
28 mph over the legal limit	75 days
29 mph over the legal limit	80 days
30 mph over the legal limit	90 days
31 mph over the legal limit	100 days
32 mph over the legal limit	110 days
33 mph over the legal limit	120 days
34 mph over the legal limit	130 days
35 mph over the legal limit	140 days
36 mph over the legal limit	150 days
37 mph over the legal limit	160 days
38 mph over the legal limit	170 days
39 mph over the legal limit	180 days
40 mph over the legal limit	190 days
41 mph over the legal limit	210 days
42 mph over the legal limit	230 days
43 mph over the legal limit	250 days
44 mph over the legal limit	270 days
45 mph over the legal limit	290 days
46 mph over the legal limit	310 days
47 mph over the legal limit	330 days
48 mph over the legal limit	350 days
49 mph or more over the legal limit	one year

This rule is intended to implement Iowa Code sections 321.210 and 321.491.

761—615.18(321) Suspension under the nonresident violator compact.

615.18(1) The department may suspend a person's license when a report is received from another state under the nonresident violator compact that an Iowa licensee has failed to comply with the terms of a traffic citation.

615.18(2) The suspension shall begin 30 days after the department's notice of suspension is served.

615.18(3) The suspension shall continue until the department issues a notice terminating the suspension. The department shall terminate the suspension when it receives evidence of compliance with the terms of the citation.

This rule is intended to implement Iowa Code sections 321.210 and 321.513.

761—615.19(321) Suspension for a charge of vehicular homicide. In accordance with Iowa Code section 321.210D, the department shall suspend a person's license when the department receives notice from the clerk of the district court that an indictment or information has been filed charging the person with homicide by vehicle under Iowa Code section 707.6A, subsection 1 or 2. The suspension shall begin ten days after the department's suspension notice is issued.

This rule is intended to implement Iowa Code section 321.210D.

761—615.20(321) Suspension for moving violation during probation. The department may suspend the license of a person convicted of a moving violation pursuant to Iowa Code section 321.210C. The suspension period shall not exceed one year.

This rule is intended to implement Iowa Code section 321.210C.

761—615.21(321) Suspension of a minor's school license and minor's restricted license.

615.21(1) *Suspension of a minor's school license.*

a. The department may suspend a minor's school license upon receiving notice of the licensee's conviction for one moving violation or evidence of one or more accidents chargeable to the licensee.

b. The department may also suspend a minor's school license when the department receives written notice from a peace officer, parent, custodian or guardian, school superintendent, or superintendent's designee that the licensee has violated the restrictions of the license.

c. The suspension period under this subrule shall be at least 30 days.

615.21(2) *Suspension of a minor's restricted license.* The department may suspend a minor's restricted license upon receiving notice of the licensee's conviction for one moving violation. The suspension period shall be at least 30 days.

This rule is intended to implement Iowa Code sections 321.178 and 321.194.

761—615.22(321) Suspension for nonpayment of fine, penalty, surcharge or court costs.

615.22(1) *Report to the department.* The department shall suspend a person's privilege to operate motor vehicles in Iowa:

a. When the department is notified by a clerk of the district court on Form No. 431037 that the person has been convicted of violating a law regulating the operation of motor vehicles, that the person has failed to pay the fine, penalty, surcharge or court costs arising out of the conviction, and that 60 days have elapsed since the person was mailed a notice of nonpayment from the clerk of the district court, and

b. When, in accordance with subrule 615.22(2), the person has not timely raised the defense of inability to pay, or the department determines that the person is able to pay the fine, penalty, surcharge and court costs.

615.22(2) *Ability to pay.*

a. The department shall presume that a person is able to pay the fine, penalty, surcharge and court costs when it receives the "Notice to Suspend" copy of Form No. 431037 from the clerk of the district court.

b. The department shall not consider inability to pay as a defense to license suspension unless the person files Form No. 431038 with the department within 45 days after the clerk of the district court mailed notice of nonpayment to the person.

c. If the department determines that the person is unable to pay, the department shall notify the person and the clerk of the district court of that decision and shall take no further action. If the department determines that the person is able to pay, the department shall suspend the person's privilege to operate motor vehicles in Iowa as outlined in subrule 615.22(1).

615.22(3) *Suspension.*

a. The suspension period shall begin 30 days after the notice of suspension is served.

b. The suspension shall continue until the department has issued a notice terminating the suspension. The department shall terminate the suspension when it receives evidence that all appropriate payments have been made.

c. An informal settlement, hearing or appeal to contest the suspension shall be limited to a determination of whether the facts required by Iowa Code section 321.210A and this rule are true. The merits of the conviction shall not be considered.

This rule is intended to implement Iowa Code section 321.210A.

761—615.23(321) Suspensions for juveniles.

615.23(1) *Suspension for juveniles adjudicated delinquent for certain offenses.*

a. Pursuant to Iowa Code section 321.213A, the department shall suspend the license of a person for one year upon receipt of an adjudication and dispositional order from the clerk of the juvenile court.

b. The department may issue to a person suspended under this subrule a temporary restricted license in accordance with rule 761—615.45(321) if issuance is permitted under Iowa Code section 321.215 and the person is otherwise eligible for the license. To obtain a temporary restricted license that is valid for educational purposes, the applicant must meet the requirements for issuance of a minor's school license under Iowa Code section 321.194 and rule 761—602.26(321).

615.23(2) *Suspension for juvenile's failure to attend school.*

a. The department shall suspend the driver's license of a person under the age of 18 upon receipt of notification from the appropriate school authority that the person does not attend school.

b. "School" means a public school, an accredited nonpublic school, competent private instruction in accordance with the provisions of Iowa Code chapter 299A, an alternative school or adult education classes.

c. "Appropriate school authority" means the superintendent of a public school or the chief administrator of an accredited nonpublic school, an alternative school or adult education.

d. The suspension shall continue until the person reaches the age of 18 or until the department receives notification from the appropriate school authority that the person is attending school.

e. The department may issue to the person a minor's restricted license in accordance with Iowa Code section 321.178 and rule 761—602.25(321) if the person is eligible for the license.

This rule is intended to implement Iowa Code sections 232.52(2)*"a"*(4), 299.1B, 321.213, 321.213A, 321.213B, and 321.215.

761—615.24(252J,261) Suspension upon receipt of a certificate of noncompliance.

615.24(1) *From child support recovery unit.*

a. The department shall suspend a person's Iowa-issued driver's license upon receipt of a certificate of noncompliance from the child support recovery unit.

b. The suspension shall begin 30 days after the department's notice of suspension is served.

c. The suspension shall continue until receipt of a withdrawal of the certificate of noncompliance from the child support recovery unit.

d. The filing of an application pursuant to Iowa Code section 252J.9 stays the suspension pending the outcome of the district court hearing.

615.24(2) *From college student aid commission.*

a. The department shall suspend a person's Iowa-issued driver's license upon receipt of a certificate of noncompliance from the college student aid commission.

b. The suspension shall begin 30 days after the department's notice of suspension is served.

c. The suspension shall continue until receipt of a withdrawal of the certificate of noncompliance from the college student aid commission.

d. The filing of an application pursuant to Iowa Code section 261.127 stays the suspension pending the outcome of the district court hearing.

615.24(3) *From department of revenue.* Rescinded IAB 2/8/12, effective 3/14/12.

This rule is intended to implement Iowa Code sections 252J.1, 252J.8, 252J.9, 261.126 and 261.127.
[**ARC 7902B**, IAB 7/1/09, effective 8/5/09; **ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—615.25(321) Suspension—driver's license indebtedness clearance pilot project. Rescinded IAB 11/8/06, effective 12/13/06.

761—615.26(321) Suspension or revocation for violation of a license restriction. The department may suspend or revoke a person's license when the department receives satisfactory evidence of a

violation of a restriction imposed on the license. The suspension or revocation period shall be at least 30 days.

This rule is intended to implement Iowa Code section 321.193.

761—615.27 and **615.28** Reserved.

761—615.29(321) Mandatory revocation.

615.29(1) The department shall revoke a person's license upon receipt of a record of the person's conviction for an offense listed under Iowa Code section 321.209 or upon receipt of an order issued pursuant to Iowa Code subsection 901.5(10).

615.29(2) The department shall revoke a person's license under Iowa Code subsection 321.209(2) upon receipt of a record of the person's conviction for a felony:

a. Which provides specific factual findings by the court that a motor vehicle was used in the commission of the offense,

b. Which is accompanied by information from the prosecuting attorney indicating that a motor vehicle was used in the commission of the crime, or

c. Where the elements of the offense actually required the use of a motor vehicle.

615.29(3) The revocation period shall be at least one year except:

a. The revocation period for two convictions of reckless driving shall be at least five days and not more than 30 days.

b. The revocation period for a first offense for drag racing shall be six months if the violation did not result in personal injury or property damage.

c. The revocation period for an order issued pursuant to Iowa Code subsection 901.5(10) is 180 days.

This rule is intended to implement Iowa Code sections 321.209, 321.212, 321.261 and 707.6A.

761—615.30(321) Revocation for out-of-state offense.

615.30(1) The department may revoke an Iowa resident's license when the department is notified by another state that the person committed an offense in that state which, if committed in Iowa, would be grounds for revocation. The notice may indicate either a conviction or a final administrative decision. The period of the revocation shall be the same as if the offense had occurred in Iowa.

615.30(2) Rescinded IAB 11/20/96, effective 12/25/96.

This rule is intended to implement Iowa Code section 321.205.

761—615.31(321) Revocation for violation of a license restriction. Rescinded IAB 11/18/98, effective 12/23/98.

761—615.32(321) Extension of revocation period. The department shall extend the period of license revocation for an additional like period when the person is convicted of operating a motor vehicle while the person's license is revoked.

This rule is intended to implement Iowa Code sections 321.218 and 321J.21.

761—615.33(321) Revocation of a minor's license.

615.33(1) The department shall revoke a minor's restricted license upon receiving a record of the minor's conviction for two or more moving violations.

615.33(2) The department shall revoke a minor's school license upon receiving a record of the minor's conviction for two or more moving violations.

This rule is intended to implement Iowa Code subsection 321.178(2) and section 321.194.

761—615.34(321J) Other revocations. Rescinded IAB 11/18/98, effective 12/23/98.

761—615.35 Reserved.

761—615.36(321) Effective date of suspension, revocation, disqualification or bar. Unless otherwise specified by statute or rule, a suspension, revocation, disqualification or bar shall begin 30 days after the department's notice of suspension, revocation, disqualification or bar is served.

This rule is intended to implement Iowa Code sections 321.208, 321.209, 321.210, and 321.556.

761—615.37(321) Service of notice.

615.37(1) The department shall send a notice of denial, cancellation, suspension, revocation, disqualification or bar by first-class mail to the person's mailing address as shown on departmental records.

615.37(2) In lieu of service by mail, the notice may be delivered by a peace officer, a departmental employee, or any person over 18 years of age.

a. The person serving the notice shall prepare a certificate of personal service certifying delivery, specifying the name of the receiver, the address and the date, or certifying nondelivery.

b. The department shall pay fees for personal service of notice by a sheriff as specified in Iowa Code section 331.655. The department may also contract for personal service of notice when the department determines that it is in the best interests of the state.

615.37(3) The denial, cancellation, suspension, revocation, disqualification or bar shall become effective on the date specified in the notice.

615.37(4) The department may prepare an affidavit of mailing verifying the fact that a notice was mailed by first-class mail. To verify the mailing of a notice, the department may use its records in conjunction with U.S. Postal Service records available to the department.

615.37(5) The department shall prepare an affidavit of mailing if the department determines, under Iowa Code section 321.211A, that it failed to serve a notice of suspension or revocation. The department shall send the affidavit to the court that rendered the conviction.

This rule is intended to implement Iowa Code sections 321.16, 321.211, 321.211A, 321.556, 321J.9, 321J.12, and 331.655.

761—615.38(17A,321) Hearing and appeal process.

615.38(1) *Applicability.* This rule applies to:

a. License denials, cancellations and suspensions under Iowa Code sections 321.177 to 321.215 and 321A.4 to 321A.11 except denials under Iowa Code subsection 321.177(10) and suspensions under Iowa Code sections 321.210B, 321.210D, 321.213A and 321.213B.

b. License suspensions and revocations under Iowa Code sections 321.218 and 321J.21.

c. License revocations under Iowa Code sections 321.193 and 321.205.

d. Disqualifications from operating a commercial motor vehicle under Iowa Code section 321.208.

e. License bars under Iowa Code section 321.556.

615.38(2) *Submission of request or appeal.*

a. A person subject to a sanction listed in subrule 615.38(1) may contest the action by following the provisions of 761—Chapter 13 as supplemented by this rule.

b. A request for an informal settlement, a request for a contested case hearing, or an appeal of a presiding officer's decision shall be submitted to the director of the office of driver services at the address in 761—600.2(17A).

c. The request or appeal shall include the person's name, date of birth, driver's license or permit number, complete address and telephone number, and the name, address and telephone number of the person's attorney, if any.

615.38(3) *Informal settlement or hearing.*

a. The person may request an informal settlement. Following an unsuccessful informal settlement procedure, or instead of that procedure, the person may request a contested case hearing.

b. Notwithstanding paragraph *"a"* of this subrule, a request received from a person who has participated in a driver improvement interview on the same matter shall be deemed a request for a contested case hearing.

c. A request for an informal settlement or a request for a contested case hearing shall be deemed timely submitted if it is delivered to the director of the office of driver services or postmarked within the time period specified in the department's notice of the sanction.

(1) Unless a longer time period is specified in the notice or another time period is specified by statute or rule, the time period shall be 20 days after the notice is served.

(2) If the department fails to specify a time period in the notice, the request may be submitted at any time.

615.38(4) *Appeal.* An appeal of a presiding officer's decision shall be submitted in accordance with 761—13.7(17A).

615.38(5) *Stay of sanction.*

a. When the department receives a properly submitted, timely request for an informal settlement, request for a contested case hearing or appeal of a presiding officer's proposed decision regarding a sanction listed in subrule 615.38(1), it shall, after a review of its records to determine eligibility, stay (stop) the sanction pending the outcome of the settlement, hearing or appeal unless prohibited by statute or rule or unless otherwise specified by the requester/appellant.

(1) If the stay is granted, the department shall issue and send to the person a notice granting the stay. The stay is effective on the date of issuance. The notice allows the person to drive while the sanction is stayed if the license is valid and no other sanction is in effect.

(2) A person whose stay authorizes driving privileges shall carry the notice of stay at all times while driving.

b. Of the sanctions listed in subrule 615.38(1), the department shall not stay the following, and the person's driving privileges do not continue:

(1) A suspension for incapability.

(2) A denial.

(3) A disqualification from operating a commercial motor vehicle.

(4) A suspension under Iowa Code section 321.180B.

(5) A suspension or revocation under Iowa Code section 321.218 or 321J.21.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177 to 321.215, 321.218, 321.556, 321A.4 to 321A.11, and 321J.21.

761—615.39(321) Surrender of license. A person whose Iowa license has been canceled, suspended, revoked or barred or who has been disqualified from operating a commercial motor vehicle shall surrender the license to the designated representative of the department on or before the effective date of the sanction.

This rule is intended to implement Iowa Code sections 321.201, 321.208, 321.212, 321.216, 321.556, and 321A.31.

761—615.40(321) License reinstatement or reissue. A person who becomes eligible for a license after a denial, cancellation, suspension, revocation, bar or disqualification shall be notified by the department to appear before a driver license examiner to obtain or reinstate the license. The license may be issued if the person has:

615.40(1) Filed proof of financial responsibility under Iowa Code chapter 321A, when required, for all vehicles to be operated. The class of license issued will depend on the examinations passed and other qualifications of the applicant. Regardless of the class of license issued, the license shall be valid only for the operation of the motor vehicles covered under the proof of financial responsibility filed by the applicant.

615.40(2) Paid the civil penalty when required. The civil penalty is specified in Iowa Code Supplement section 321.218A or 321A.32A.

615.40(3) Complied with the specific instructions given in the department's notice terminating the sanction.

615.40(4) Successfully completed the required driver license examination.

615.40(5) Paid the reinstatement fee when required. The reinstatement fee is specified in Iowa Code section 321.191.

615.40(6) Paid the appropriate license fee or duplicate license fee. These fees are specified in Iowa Code sections 321.191 and 321.195.

This rule is intended to implement Iowa Code sections 321.186, 321.191, 321.195, 321.208, 321.212, and 321A.17 and Iowa Code Supplement sections 321.218A and 321A.32A.
[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—615.41 Reserved.

761—615.42(321) Remedial driver improvement action under Iowa Code section 321.180B.

615.42(1) The department shall require remedial driver improvement action when a person holding an instruction permit, an intermediate license or a full-privilege driver's license under Iowa Code section 321.180B is convicted of a moving violation or has a contributive accident and the violation or accident occurred during the term of the instruction permit or intermediate license.

615.42(2) Completion of remedial driver improvement action means any or all of the following as determined by the department: suspension, safety advisory letter, additional restriction(s), vision screening, knowledge examination, and driving examination.

615.42(3) A suspension period under this rule shall be for no less than 30 days nor longer than one year. A person whose driving privilege has been suspended under this rule is not eligible for a temporary restricted license.

615.42(4) Remedial driver improvement action or suspension under this rule terminates when a person attains the age of 18.

This rule is intended to implement Iowa Code section 321.180B.
[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—615.43(321) Driver improvement program.

615.43(1) *When required.*

a. In lieu of suspension, the department may require the following persons to attend and successfully complete, at the person's own expense, a driver improvement program approved by the department:

(1) A habitual violator.

(2) A person who is convicted for speeding at least 25 but not more than 29 miles per hour over the legal limit.

(3) A person whose license is subject to suspension under Iowa Code section 321.210C.

b. However, a person shall not be assigned to a driver improvement program more than once within a two-year period.

615.43(2) *Scheduling.* The department shall schedule attendance at a program nearest the person's last known address.

a. One request for rescheduling may be granted if the program begins within 30 days of the originally scheduled date and if space is available.

b. A request to attend a program in another state may be granted if the curriculum is approved by the department.

615.43(3) *Probation.* When a person is required to attend and successfully complete a driver improvement program, the department shall also require the person to complete a probationary driving period not to exceed one year. One conviction for a moving violation committed during probation may result in suspension of the person's license. The suspension period shall be at least 90 days, unless reduced by a driver's license hearing officer based on mitigating circumstances.

615.43(4) *Failure to attend.* The department shall suspend the license of a person who is required to attend a driver improvement program and who does not attend, or does not successfully complete, the program. The suspension period shall be at least 90 days.

This rule is intended to implement Iowa Code sections 321.210 and 321.210C.

761—615.44(321) Driver improvement interview.

615.44(1) The department may require a person whose license is subject to suspension to appear for a driver improvement interview.

615.44(2) The department may take one or more of these remedial actions following the interview:

a. Suspend the person's license and issue a temporary driving permit which will allow the person to drive until the effective date of the suspension.

b. Place the person on probation. One conviction for a moving violation committed during probation may result in suspension of the person's license.

c. Restrict the person's license to specified vehicles, times, routes, locations, or other conditions.

d. Order the person to successfully complete a driver improvement program in accordance with rule 615.43(321).

e. Take no further action.

615.44(3) The department shall suspend the license of a person who is required to appear for a driver improvement interview and fails to appear.

This rule is intended to implement Iowa Code sections 321.193 and 321.210.

761—615.45(321) Temporary restricted license (work permit).

615.45(1) *Ineligibility.* The department shall not issue a temporary restricted license under Iowa Code subsection 321.215(1) to an applicant:

a. Whose license has been denied or canceled.

b. Whose license has been suspended for incapability.

c. Whose license has been suspended for noncompliance with the financial responsibility law.

d. Whose minor's school license or minor's restricted license has been suspended or revoked.

e. Whose license has been suspended for failure to pay a fine, penalty, surcharge or court costs.

f. Whose period of suspension or revocation has been extended for operating a motor vehicle while under suspension or revocation.

g. Whose license has been mandatorily revoked under Iowa Code section 321.209, subsections 1 to 5 or subsection 7, or for a second or subsequent conviction for drag racing.

h. Whose license has been suspended under the nonresident violator compact.

i. Who is barred under Iowa Code section 321.560.

j. Whose license has been suspended or revoked for a drug or drug-related offense.

k. Whose license has been suspended due to receipt of a certificate of noncompliance from the child support recovery unit.

l. Whose license has been suspended due to receipt of a certificate of noncompliance from the college student aid commission.

m. Whose license has been suspended for a charge of vehicular homicide.

n. Who has been suspended under Iowa Code subsection 321.180B(3).

615.45(2) *Application.*

a. To obtain a temporary restricted license, an applicant shall submit a written request for an interview with a driver's license hearing officer. The request shall be submitted to the office of driver services at the address in 761—600.2(17A).

b. If the driver's license hearing officer approves the issuance of a temporary restricted license, the officer shall furnish to the applicant application Form 430100, which is to be completed and submitted to the office of driver services.

c. A temporary restricted license issued for employment may include permission for the licensee to transport dependent children to and from a location for child care when that activity is essential to continuation of the licensee's employment.

615.45(3) *Statements.* A person applying for a temporary restricted license shall submit all of the following statements that apply to the person's situation. Each statement shall explain the need for the license and shall list specific places and times for the activity which can be verified by the department.

a. A statement from the applicant.

b. A statement from the applicant's employer unless the applicant is self-employed including, when applicable, verification that the applicant's use of a child care facility is essential to the applicant's continued employment.

c. A statement from the health care provider if the applicant or the applicant's dependent requires continuing health care.

d. A statement from the educational institution in which the applicant is enrolled.

e. A statement from the substance abuse treatment program in which the applicant is participating.

f. A copy of the court order for community service and a statement describing the assigned community service from the responsible supervisor.

g. A statement from the child care provider.

615.45(4) *Additional requirements.* An applicant for a temporary restricted license shall also:

a. Provide a description of all motor vehicles to be operated under the temporary restricted license.

b. File proof of financial responsibility under Iowa Code chapter 321A, if required, for all motor vehicles to be operated under the temporary restricted license.

c. Pay the required civil penalty specified in Iowa Code Supplement section 321.218A or 321A.32A.

615.45(5) *Issuance and restrictions.*

a. When the application is approved and all requirements are met, the applicant shall be notified by the department to appear before a driver's license examiner. The applicant shall pass the appropriate examination for the type of vehicle to be operated under the temporary restricted license. An Iowa resident shall also pay the reinstatement and license fees.

b. The department shall determine the restrictions to be imposed by the temporary restricted license. The licensee shall apply to the department in writing with a justification for any requested change in license restrictions.

615.45(6) *Denial.* An applicant who has been denied a temporary restricted license or who contests the license restrictions imposed by the department may contest the decision in accordance with rule 761—615.38(321).

These rules are intended to implement Iowa Code chapter 321A and sections 252J.8, 321.177, 321.178, 321.184, 321.185, 321.186, 321.189, 321.191, 321.193, 321.194, 321.201, 321.205, 321.209, 321.210, 321.210A, 321.212, 321.213A, 321.213B, 321.215, 321.218, 321.513, and 321.560 and Iowa Code Supplement sections 321.218A and 321A.32A.

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◊ Two or more ARCs

CHAPTER 630
NONOPERATOR'S IDENTIFICATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C)Ch 12]

761—630.1(321) General information.

630.1(1) The department shall issue a nonoperator's identification card only to an Iowa resident who does not have a driver's license. However, a card may be issued to a person holding a temporary permit under Iowa Code section 321.181.

630.1(2) Information concerning the nonoperator's identification card is available at any driver's license examination station, or at the address in 761—600.2(17A).

761—630.2(321) Application and issuance.

630.2(1) An applicant for a nonoperator's identification card shall complete and sign an application form at a driver's license examination station. The signature shall be without qualification and shall contain only the applicant's usual signature without any other titles, characters or symbols.

630.2(2) The applicant shall present proof of age, identity and social security number as required by rule 761—601.5(321). Submission of parental consent is also required in accordance with rule 761—601.6(321).

630.2(3) The nonoperator's identification card shall be coded for identification only, as explained on the reverse side of the card. The county number shall indicate the county of residence. The card shall expire five years from the date of issue if the applicant is under the age of 70.

630.2(4) Upon the request of the cardholder, the department shall indicate on the nonoperator's identification card the presence of a medical condition, that the cardholder is a donor under the uniform anatomical gift law, or that the cardholder has in effect a medical advance directive.

630.2(5) The issuance fee is $5. However, no issuance fee shall be charged for a person whose license has been suspended for incapability pursuant to rule 761—615.14(321) or who has been denied further licensing in lieu of a suspension for incapability pursuant to rule 761—615.4(321).

630.2(6) Rescinded IAB 2/8/12, effective 3/14/12.

630.2(7) A person who seeks a nonoperator's identification card that is compliant with the REAL ID Act of 2005, 49 U.S.C. § 30301 note, as further defined in 6 CFR Part 37 ("REAL ID nonoperator's identification card"), must meet and comply with all lawful requirements for an Iowa nonoperator's identification card, and must also meet and comply with all application and documentation requirements set forth at 6 CFR Part 37, including but not limited to documentation of identity, date of birth, social security number, address of principal residence, and evidence of lawful status in the United States. Documents and information provided to fulfill REAL ID requirements must be verified as required in 6 CFR 37.13. An applicant for a REAL ID nonoperator's identification card is subject to a mandatory facial image capture that meets the requirements of 6 CFR 37.11(a). A REAL ID nonoperator's identification card may not be issued, reissued, or renewed except as permitted in 6 CFR Part 37 and may not be issued, reissued, or renewed by any procedure, in any circumstance, to any person, or for any term prohibited under 6 CFR Part 37. The information on the front of any REAL ID nonoperator's identification card must include all information and markings required by 6 CFR 37.17. Nothing in this subrule requires a person to obtain a REAL ID nonoperator's identification card.

[**ARC 8339B**, IAB 12/2/09, effective 12/21/09; **ARC 8514B**, IAB 2/10/10, effective 3/17/10; **ARC 9991B**, IAB 2/8/12, effective 3/14/12]

761—630.3(321) Duplicate card.

630.3(1) *Lost or destroyed card.* To replace a nonoperator's identification card that is lost or destroyed, the cardholder shall submit Form 430052 and proof of age, identity and social security number. The replacement fee is $3.

630.3(2) *Voluntary replacement.* To voluntarily replace a nonoperator's identification card, the cardholder shall surrender to the department the card to be replaced. The reasons a card may be voluntarily replaced and any additional supporting documentation required are the same as those listed in subrule 761—605.11(2), paragraphs *"a"* to *"f."* The fee for voluntary replacement is $1.

761—630.4(321) Cancellation. The department shall cancel a nonoperator's identification card upon receipt of evidence that the person was not entitled or is no longer entitled to a card, failed to give correct information, committed fraud in applying or used the card unlawfully.

These rules are intended to implement Iowa Code sections 321.189, 321.190, 321.192, 321.195, 321.216, 321.216A, 321.216B and 321.216C, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note) and 6 CFR Part 37.

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